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Andrew F. Holmes M.D., LL.D., M.R.C.S. (1797-1860)

TO Andrew F. Holmes and his three colleagues, Robertson, Caldwell and Stephenson, is attributed the establishment of the Montreal Medical Institution. In 1822, when it was organized, Holmes agreed to lecture on Chemistry, Pharmacy and Materia Medica. This organization later became the Medical Faculty of McGill University. In 1854 Andrew Holmes became the first Dean of the faculty, which position he held until his death.

Holmes was born in Cadiz, Spain. The ship in which his parents were travelling was captured by a French frigate and they were interned there. In 1801 the family arrived at Quebec, later moving to Montreal. Holmes was a pupil of Dr. Arnoldi, later continuing his studies abroad. In the year 1819 he returned to Canada and practised with his former teacher.

A dark man, short and slight in stature, Holmes was slightly stooped. He had a quiet, retiring manner but possessed an abundance of zeal, diligence and alertness. Christian principles characterized his life and he was known and respected for his beliefs.

Much of his free time was devoted to the study of the natural sciences. His extensive collection of the plants of Canada he presented to the Redpath Museum of McGill University. The library of McGill also benefited by his energies and he contributed, in no small measure, to building its collection of books.

Holmes was one of the first physicians in charge of the Montreal General Hospital and a member of its medical board. He was also active in all professional associations and for three years was president of the College of Physicians and Surgeons of Lower Canada.

On October 9th, 1860, Andrew Holmes passed away suddenly. The Holmes Gold Medal awarded for the highest aggregate of marks obtained in the medical course was established in his honour in 1865. The ambition of Andrew Holmes to elevate the practice of medicine in Canada, still further encourages William R. Warner & Company to maintain their policy of Therapeutic Exactness . . . Pharmaceutical Excellence . . . One price and one discount to all.

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Reader's Guide

Our "blue-dot special" this month consists of a valuable series of articles on Diabetes Mellitus. Twenty-five years ago the prognosis in a diagnosed case of this disease was very poor. Today, thanks to the genius of two outstanding Canadian physicians, living may be nearly normal for those so afflicted. Describing the various aspects of the disease comes the article by **Dr. F. Gerard Allison.** Dr. Allison is a specialist in the field of internal medicine and is on the medical staff of the Winnipeg General Hospital. Until recently **Mrs. Florence M. Wilson** was clinical instructor in medical nursing at the W.G.H. We are happy to have this second excellent article from Mrs. Wilson. You will recall that she was the author of the stimulating challenge to head nurses which was published in August, 1945. We are proud to have Mrs. Wilson as the convener of the *Canadian Nurse* Committee in Manitoba. **Isobell Barron** is on the staff of the Victorian Order of Nurses in Winnipeg. Since much of the routine care of diabetics is carried on in the home, the public health nurse has an important role in the combined picture.

Ten years ago the American Academy of Pediatrics passed a definition on the interpretation of prematurity which stated that "a premature infant is one who weighs 2,500 grams or less (5½ pounds) at birth regardless of the period of gestation". The immediate deduction would be that such an infant is not fully prepared for normal, independent, extra-uterine life. Very special care is necessary and a description of some of the features of the nursing care has been prepared for us by **Elva M. Hewitt,** prenatal supervisor with the Canadian Mothercraft Society of Toronto.

Grace Giles, travelling instructor of the Saskatchewan Registered Nurses Association, won first place in the 1945 contest sponsored by the *Journal.* Her thoughtful analysis of nursing conditions as she sees them, her suggestions for improving these things are worthy of consideration.

We are indebted to *The Canadian Hospital,* the official Journal of the Canadian Hospital Council, for permission, graciously given, to reprint the interesting story **Elizabeth K. McCann** has written around the opinions of various superintendents of nursing. Other types of students live at home, why not nursing students? After you have read Miss McCann's summary, write us your opinions on the topic. Until recently, Miss McCann was on the teaching staff of the Vancouver General Hospital. Latterly, she has been taking post-graduate work in the operating-room technique.

Since the pre- and post-operative nursing care of an infant suffering from pyloric stenosis is of greatest importance, the description of this care by **Patricia Raymond** will prove very useful. Miss Raymond is head nurse of the children's ward at the Royal Victoria Hospital, Montreal. **Lillian Thomson's** suggestions regarding the conduct of an interview will be exceedingly useful tools for every public health nurse to adopt. Miss Thomson is with the National Office of the Y.W.C.A. in Toronto. The description of the administration of the new drug, Thiouracil (pronounced in five syllables with the accent on "ur") gives new hope to hyperthyroid patients. **Sara Brehaut** and **Mildred Thompson** are Charlottetown nurses.

The **Index** of the material in Volume 41, all of the issues in the 1945 editions, is now in course of preparation. It will be mailed out to each subscriber together with the April issue of the *Journal.* In the meantime, some copies will be available from the office of *The Canadian Nurse* by the time you are reading this. If you wish to receive a copy in advance of April, send ten cents in coin or stamps to this office. The copies which will be mailed to subscribers later are, of course, included in the regular subscription.

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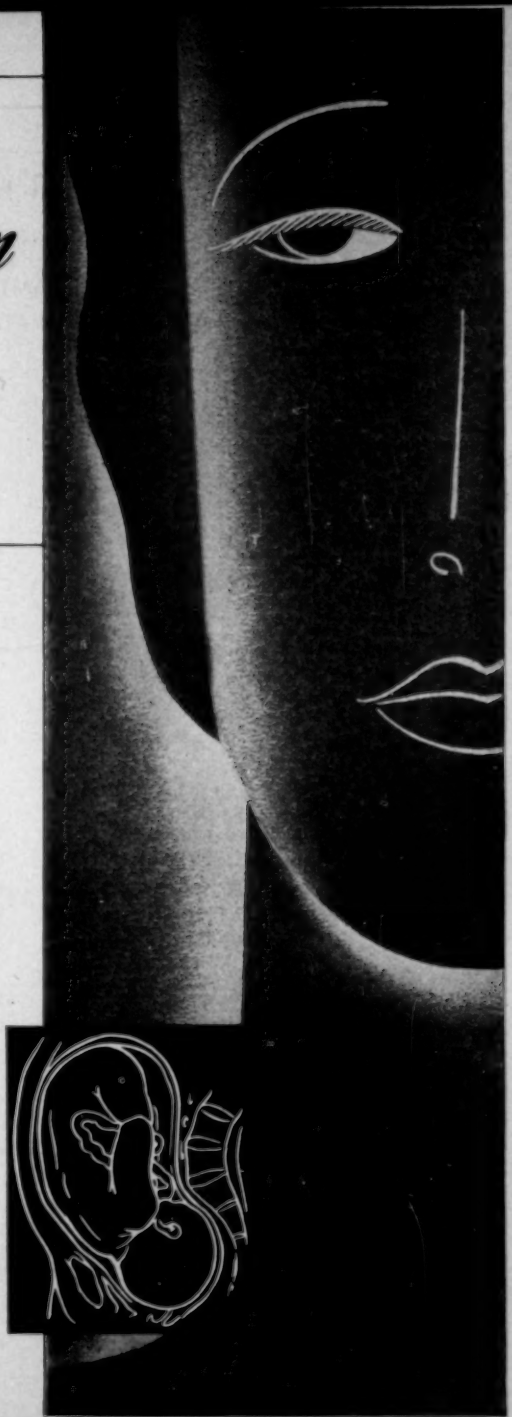
1. LUND, CURTIS, J., KIMBLE, Marion S., Plasma Vitamin A and Carotene of the Newborn Infant, Am. J. Obs. & Gynec. 46:207:1943 (August).



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★ Colebrook, L. (1933) *J. Obstet. & Gynaec.*, **40**, 977.

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THE review quoted above indicates the importance of calcium, phosphorus, and vitamin D during pregnancy, for the mother's protection and to give her baby the needed materials for building sound bones and teeth.

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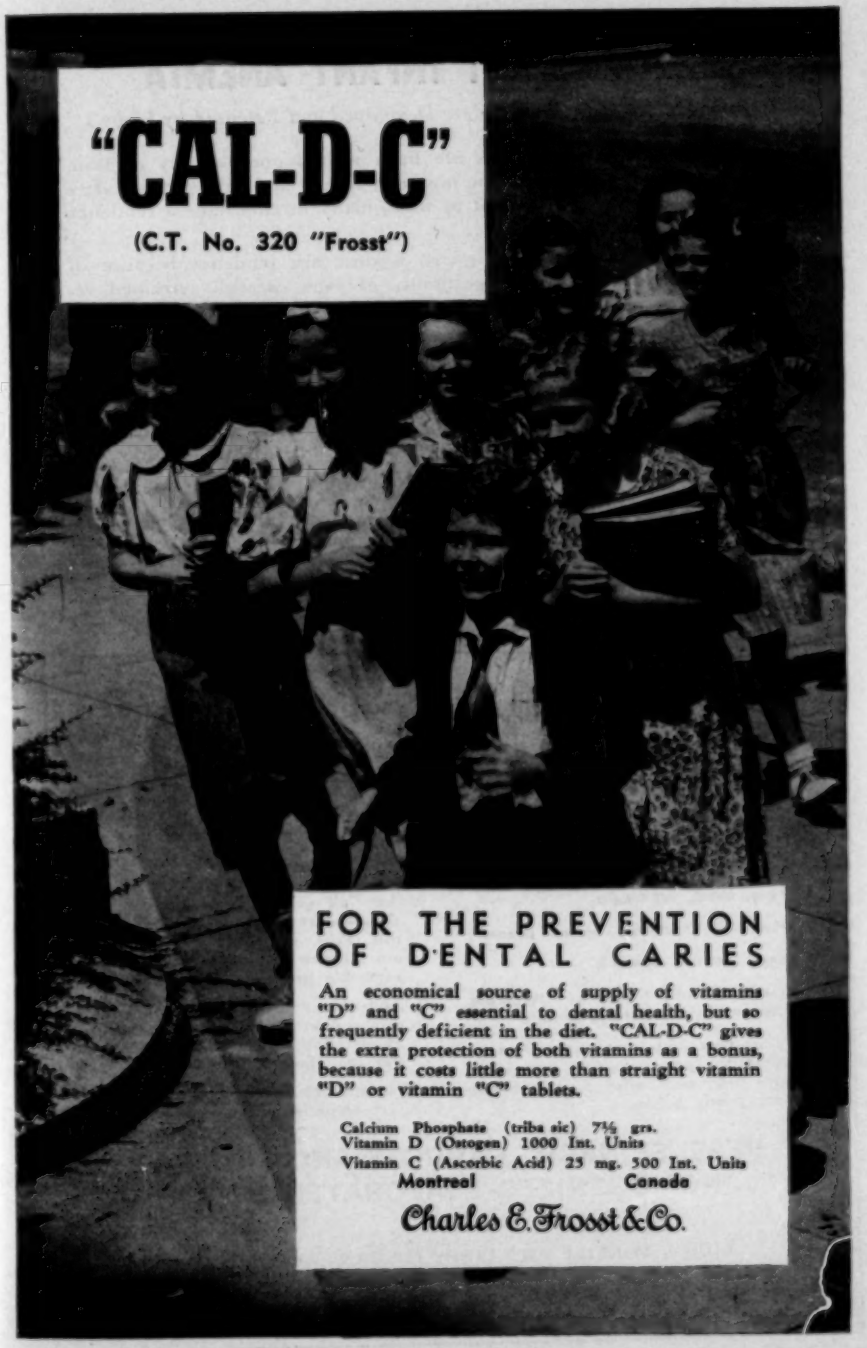
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REFERENCES: 1. Med. Rec., 155:316, 1942. 2. West. J. Surg., Obst. & Gynec., 51:150, 1943. 3. Clin. Med. & Surg., 46:327, 1939.

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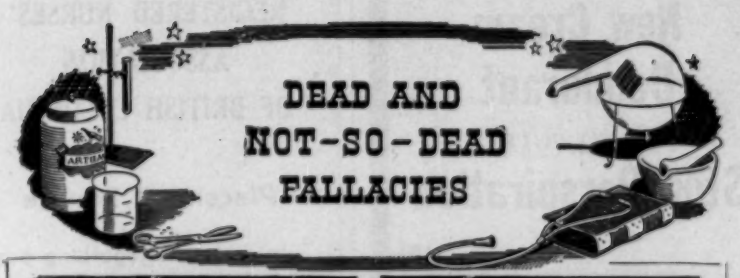

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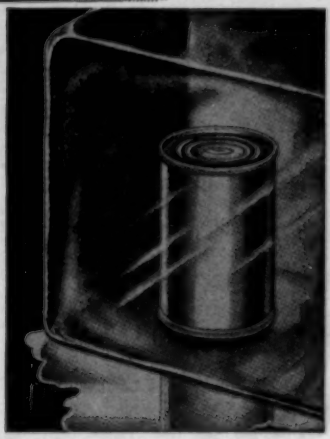

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A MONTHLY JOURNAL FOR THE NURSES OF CANADA
PUBLISHED BY THE CANADIAN NURSES ASSOCIATION

VOLUME FORTY-TWO NUMBER TWO

FEBRUARY 1946

The Essence of Leadership

This is the time of the year when many nursing associations are considering the election of their slates of officers, the leaders who will plan for and guide the activities of the organizations. It seems pertinent, therefore, to consider briefly what constitutes a capable leader. It is a frequently accepted axiom that leadership is an innate characteristic — either one is or one is not the type of person who is best suited to be on an executive, to be a leader. It is true that some people seem born to be in the forefront of whatever group they enter. Even as youngsters, some individuals seem automatically to assume this role. But psychologists tell us that true leadership reaches far beyond simply innate ability — it can only be acquired and will only function adequately by dint of conscious effort.

What is leadership, then? Ruth B. Freeman, in her book on Supervision in Public Health Nursing, has defined it as, "the ability to organize the resources of the group in such a manner as to realize its common objectives with the maximum degree of efficiency, while promoting to the fullest the development of each of its members". Miss Freeman indicates that "leadership must not be confused with domination or with persuasiveness, which molds the group to a pattern . . . True leadership is not the imposition of a way of behaviour upon the group, but the marshaling of the many elements of power and thinking within the group itself to define a pattern which represents the best integration of the facilities of all".

If these definitions are accepted as being valid, as applicable to nursing associations, are there any traits which will help in the recognition of suitable individuals to lead the organizations toward the desired ends? It would be altogether too simple if it were only necessary to assemble a list of desirable characteristics, tick off those supposedly possessed by each candidate and in the light

of this aggregation assign the offices in an organization. Few paragons exist who possess all of the traits one might list, in exactly the right balance. However, there are certain fundamental qualities which are inherent in or may be acquired by all good leaders. What potentialities for leadership should a particular individual possess in order to merit group confidence?

It is obvious that the relative importance of any one trait over others would be difficult to determine. No attempt has been made, therefore, to grade the following characteristics in order of importance; nor is the list exhaustive. Most studies which have been made agree that, in general, leaders are superior to non-leaders in: loyalty to, enthusiasm for, and belief in the organization or work; an understanding of and liking for people, including a sense of the personal worth of others; initiative, balanced by a sense of perspective, an ability to see the long-range program as well as the immediate details; good judgment, coupled with a sense of values and an ability to uphold decisions; dignity blended with a sense of humour and cheerfulness; sincerity and unhurried courtesy; industry and intellectual integrity.

There are times when the selection of leaders is simply the result of a happy accident. Occasionally, offices in an organization are filled by available persons regardless of their suitability. Careful thought, assessment alike of the goals to be reached and the qualities most essential in the leaders in order to reach those goals, encouragement to likely candidates, are all functions of nominating committees. Let us build strongly and wisely.

—M.E.K.

Diabetes Mellitus

F. Gerard Allison, M.D., M.R.C.P. (London)

The word diabetes is derived from the Greek word for "flowing". The ancients recognized two types of diabetes — *insipidus*, in which the urine had no taste, and *mellitus*, in which it tasted sweet, like honey. Great attention was paid to the urine in ancient days and every doctor was his own laboratory technician.

Diabetes Mellitus may be defined as a disease in which glucose is imperfectly burnt in the body, and is excreted in the urine. The site of the disease was discovered in 1889 when Minkowski noted that dogs in whom the pancreas had been removed often drank their own urine. When he tested the urine he found it contained glucose, like the urine of patients with diabetes mellitus. Small collections of cells in the pancreas, called the islets of Langerhans, produce a secretion we call insulin. This substance entering the blood enables the glucose to be burnt or metabolized. The isolation of insulin by Banting and Best in 1922 followed soon after the discovery of a method of estimating the amount of glucose in the blood. Commercial insulin is chemically extracted from the pancreas of animals.

The disease is due to degeneration of the cells in the islets of Langerhans and may occur at any age, but is commonest between forty and sixty years. Thirteen per cent of the cases are hereditary. Persons with a diabetic family history should be careful not to marry into another diabetic family or the percentage of

diabetic children would be high. Obesity and overeating are factors in causation, but the exciting cause of the onset of symptoms is usually unknown.

Symptoms

Diagnosis is easy in a case with an acute onset. Thirst, frequency, big appetite, and rapid loss of weight are characteristic. Urine and blood tests are confirmatory. But often the disease is mild, or the patient is unobservant. In either case, the typical symptoms are not indicated to the doctor, and the diagnosis is either by routine urinalysis or by investigation of suspicious minor symptoms, boils, itching of the genitalia in females, white sugary powder noted on clothes from dried urine, or stickiness of the urine.

The fall in production of insulin by the islet cells leads to a fall in the amount of glucose burnt in the body, and so to a rise in the level of blood glucose. The extra sugar excreted in the urine causes an increased flow of urine by its osmotic power; hence the patient's frequent passage of large amounts of urine. This in turn causes thirst. Starvation of the tissue cells through lack of ability to use glucose accounts simultaneously for the increased appetite and loss of weight.

In diabetes, as in the case of other chronic diseases needing long-continued treatment, for example, pernicious anemia, the greatest care must be taken in establishing the diagnosis. A number of conditions can cause glucose, or a simulation of glucose, to appear in the urine specimen. Chief among these are: using a specimen bottle, which has contained something sweet without thoroughly washing it; an intravenous injection of glucose solution; renal glycosuria; hyperthyroidism; lactosuria of the parturient. A high blood sugar while fasting or a sugar tolerance test in which the blood sugar level goes too high and stays too high for too long, confirm the diagnosis of diabetes mellitus.

Treatment

Treatment of an uncomplicated case resolves itself into a trial and error method of finding the right diet, the right dosage of insulin, if needed, and education of the patient in the management of the disease. This process is most easily carried out in hospital. The only type of diabetes which may be cured is that occurring in obese persons where weight reduction leads to a reduction of fat in the liver and normal storage of glycogen may be resumed.

The diet must be planned to maintain normal weight, energy and vitamin requirements, particularly the vitamin B complex. A fixed intake of carbohydrates, proteins, fats, and calories is established and the total daily urinary output of glucose is measured in grams. The carbohydrate intake is limited to about half that of normal people. Patients maintaining an output of over 20 grams of glucose daily, after about a week on a suitable diet, need insulin. The others can get along on diet alone unless they become ill.

The milder cases, in whom reduction of the carbohydrate in the diet to about 150 grams daily stops the glycosuria, may be treated on a simplified form of diet therapy in which all foods except carbohydrates are allowed as desired. All sweets and starches are forbidden except for one dish of cereal, one potato, and four slices of bread daily. A simplified diet is more apt to be followed than one which is more complicated.

A severe case must be started on insulin, on admission to hospital. About one-third as many units of Protamine Zinc insulin is given daily before breakfast as there are grams of glucose passed in twenty-four hours on diet treatment alone. Protamine Zinc insulin is preferred to plain insulin as its action lasts

for over twenty-four hours, so that one daily injection is sufficient in most cases. Patients needing over 40 units a day are too subject to insulin shock on pure Protamine Zinc insulin, and may either receive an extra injection of plain insulin, or have a mixture of three parts plain insulin to two parts Protamine Zinc insulin.

A record is kept of the patient's weight, diet, insulin, daily output of glucose in grams, and per cent of sugar in the before-breakfast specimen of urine. The dose of insulin is altered every two or three days until there is just a trace of sugar in the before-breakfast specimen. This is evidence that the Protamine Zinc insulin has not lowered the blood sugar during the night-time fast to a level where insulin shock is likely. A cup of orange juice containing a tablespoonful of sugar is kept at the bedside for the patient to take if shock appears. Candy may be carried in the pocket for the same purpose. If the total output of grams of glucose is not declining satisfactorily after a few days, a specimen of urine is examined after each of the three regular meals and the bedtime meal. If much sugar is being passed after one meal, and none after another, a slice of bread is removed from the sugared meal and added to the sugar-free meal. Sometimes it is necessary to add meat or cheese to the bedtime meal to prevent early morning insulin shock. The protein in these foods yields some glucose, but much more slowly than would a carbohydrate food like bread. The patient's regimen is considered balanced when, on a diet adequate for work, he or she has a total output of glucose of ten grams or less, and no insulin shock.

While being balanced the patient is up and about, may help the nurses, and may leave the hospital for a few hours at a time, as long as all food is eaten at the hospital and all urine passed there. The patient studies his disease, particularly diabetic dietetics and insulin shock, learns to prepare his insulin syringe and give the injections, and learns to test his urine. Benedict's solution is the standard re-agent for testing glucose in urine, but for quickness and convenience the patient may also learn to use the Clinitest or Galatest methods. The method of testing for ketones with 5 per cent ferric chloride should also be explained. The patient must be told that insulin is very important if he is ill, and may need to be increased then. He must never stop insulin if he loses his appetite. Under these circumstances he can maintain his carbohydrate intake and prevent shock with sweet drinks. The ferric chloride test for ketones should always be done if he does not feel well. If positive, the doctor should be called at once. A false positive test may appear if aspirin has previously been taken. The test is very simple. It is done by mixing equal parts of urine and 5 per cent ferric chloride and noting if the colour changes instantly to a smoky red.

Insulin Shock

Every diabetic, every relative of a diabetic, and every nurse must be familiar with this condition as early treatment is so important. Insulin shock is due to too much insulin in relation to the amount of carbohydrate in the body. Shock results when the blood sugar level drops too low. Most normal people have experienced a mild form of the condition when they have missed a meal and noted hunger, weakness, sweating, and tremor. In addition, the diabetic may notice confusion, dizziness, and headache.

If there is no sweet food at hand and the drop in blood sugar is severe, the diabetic will become deeply unconscious very quickly. The presence of excessive sweating usually distinguishes this condition from diabetic coma, in which the patient is dehydrated, with a dry skin, dry tongue, and soft eyeballs. If in doubt it is better to give a sweet drink instantly as this will not injure a pa-

tient in incipient coma, whereas its lack will often allow a shock patient to become unconscious, necessitating intravenous glucose, sweet drinks by stomach tube, or, in milder cases, a hypodermic of adrenalin.

Diabetic Coma

This is a medical emergency requiring skilled treatment administered promptly, and continuous supervision, if the patient's life is to be saved. The usual causes of coma are neglect of insulin injection, breaking diet, or the presence of an infection increasing the need for insulin.

Symptoms which may be encountered are headache, drowsiness, air hunger, vomiting, and abdominal pain. If untreated, coma will ensue. The high blood sugar and high content of urinary sugar causes a large output of urine which dehydrates the patient. The poor combustion of glucose in the body leads to imperfect combustion of fats with the accumulation in the blood of ketones, which are toxic end-products or poor fat combustion. The usual ketones for which urinary tests are done are diabetic acid and acetone. The ferric chloride test has already been described. The nitroprusside test is more sensitive but also more complicated.

The immediate needs for a coma patient are for large amounts of plain insulin, intravenous saline, and warmth. Usually the stomach is washed out and an enema given. It is generally advisable to insert an in-dwelling catheter so that fresh urine specimens may be obtained and tested each hour for sugar percentage and ketones until the patient is out of danger.

If possible, blood specimens should be taken under oil and tested at once for blood sugar and carbon dioxide combining power. These tests indicate the severity of the coma and give a rough indication of the amount of insulin necessary. Root, writing in the *Journal of the American Medical Association* (1945: 127, p. 557), attributes his splendid record of only two deaths in 123 coma cases to large doses of insulin in the early stages, with no administration of glucose for the first six hours of treatment. He gives a drowsy patient with blood pressure over 100, approximately 75 units of insulin initially, whereas a comatose, dehydrated patient with a low blood pressure will be given 50 units intravenously and 100 units subcutaneously on admission; 1500 cc. normal saline is given intravenously and another 1500 by subcutaneous drip.

As soon as the percentage of sugar in the urine begins to fall, the amount of the insulin injections is reduced so as to avoid sending the patient from coma to shock. After six hours, glucose may be given by mouth or intravenously if the blood and urine sugar are falling but ketones still persist necessitating frequent insulin injections.

Other Complications

Most other complications of diabetes are due to two factors—the first, that a high blood sugar makes the patient a good culture medium for bacteria, and the second, that diabetes predisposes to arteriosclerosis, possibly due to the high blood cholesterol found in this disease.

The commonest infections are boils and tuberculosis. The latter disease may give very few symptoms in diabetics, and for this reason every diabetic should have x-ray pictures of the chest taken from time to time.

Arteriosclerosis leads to leg gangrene, strokes, angina pectoris, or coronary occlusion. Cataracts are also a common diabetic complication.

If the diabetic's diet is deficient in vitamin B he is liable to neuritis; if deficient in vitamin K occular hemorrhages are more common.

Routine Orders

Unless a patient is in coma or a surgical case, measuring intake of fluids is unnecessary. Measurement of output is essential for the estimation of daily output of glucose per twenty-four hours. The before-breakfast specimen and the twenty-four hour specimen should be done routinely for sugar while the patient is in hospital. Additional specimens can be examined if specially ordered. The patient's weight should be charted about twice a week.

The Diabetic and the Hospital Nurse

Florence M. Wilson, B.Sc.

If a nurse were given the choice of learning about only one disease in the field of internal medicine, she should make diabetes mellitus her choice. Why should the study of this one disease be so important? Diabetes mellitus is a common disease. It is a disease which cannot be cured, but can be controlled, and the control of diabetes depends upon the diabetic understanding his disease. The diabetic's understanding of his disease depends upon adequate instruction, and the nurse can and should play an important part in the instruction of every diabetic with whom she comes in contact. Obviously then, it is most necessary that the nurse understand thoroughly whereof she speaks.

Quite apart from the necessity of a nurse understanding diabetes mellitus in order that she may teach her diabetic patients adequately, the disease is an extremely interesting one to study. No two diabetics are alike, and it is fascinating to watch methods of treatment and their effect on different patients. Above all, is the thrill of taking part in bringing a patient out of diabetic coma.

Ideally, the diabetic patients in a hospital should all be together on one ward, since the nurses caring for them understand the routine more thoroughly, and patients can be given a more organized course of instruction. However, in smaller hospitals, and even in many large ones, this is not possible; thus we find diabetic patients scattered throughout medical, surgical and pediatric wards. Bearing this in mind, the nursing care of a diabetic in hospital will be presented under the following headings:

1. Nursing a very ill diabetic who is confined to bed.
2. Routine followed for the diabetic who is allowed out of bed.
3. Preparing the diabetic to care for himself at home.

Nursing a very ill diabetic who is confined to bed

Under this heading you can probably recall many instances of very ill patients you have cared for — diabetics with gangrenous feet, diabetics in diabetic coma, diabetics in insulin shock, or diabetics with cardiac conditions. To attempt a discussion of the nursing care of all of these very ill patients is beyond the scope of this article. Let us, therefore, consider the duties of a nurse in one of these situations — the diabetic in diabetic coma.

Assuming that the patient is admitted to hospital in coma, as Dr. Allison pointed out, there will be a history of omitting insulin, overindulgence, or of some type of infection, following which the patient will have experienced

the following symptoms: headache, drowsiness, air-hunger, vomiting and abdominal pain. His symptoms on admission to hospital in coma are usually typical: deep sighing respirations known as *Kussmaul's* breathing, dehydration shown by dry skin, soft eyeballs and dry tongue, and probably a strong odour of acetone on his breath. Laboratory examination usually reveals sugar and ketones in the urine, high blood sugar and low carbon dioxide combining power.

Such a patient requires constant nursing care, and those caring for him must remember above all to *follow the doctor's orders to the letter*. Diabetic coma is a medical emergency, and until the patient is fully conscious, he is regarded as being critically ill. The most satisfactory arrangement is to give one nurse the responsibility of caring for only this patient.

The patient is received into a warm bed, with blankets under and over him, and sideboards if he appears restless and liable to fall out of bed. Restraint is definitely undesirable, although occasionally, if the patient is extremely restless, it must be resorted to. A specimen of urine is obtained immediately and, as Dr. Allison mentioned, it is usually desirable to insert an indwelling catheter which is clamped off, and used to drain the urinary bladder as often as a specimen is required. If a gastric lavage is ordered, the nurse assists the doctor to carry out this procedure, and if an enema is to be given it is desirable to obtain the assistance of another nurse.

Once these preliminary measures have been carried out, the nurse's duties are mainly: administration of insulin; forcing fluids; collection of urine specimens; recording observations, treatments, nursing measures, etc.

The *administration of insulin* to the patient in diabetic coma is no different from its administration to any diabetic, although the doses are usually much larger, and it is important that the insulin be given exactly at the hours specified by the doctor. Since the dose depends upon the amount of sugar shown in the latest urine specimen, the order is usually given just before the time for the insulin administration, and the nurse must be extremely careful to check the order before she gives the dose.

Forcing fluids is extremely important to the patient in diabetic coma. As long as the patient is unconscious, fluids are given intravenously, and here the nurse must remain with the patient while the intravenous is running because, if he is restless, the needle may come out of the vein. When the patient is able to drink fluids, the nurse must constantly encourage him to take large quantities. Depending upon the percentage of blood sugar, the doctor will order normal saline, or glucose intravenously, and water or measured amounts of glucose by mouth.

The collection of urine specimens is also most important for the amount of glucose and ketones in the urine is the barometer upon which the doctor bases his treatment. As was mentioned above, while the patient is in coma, the use of an indwelling catheter is most satisfactory, because as a rule hourly specimens are desired. Later the patient should be able to void, though it is still necessary to collect specimens at the intervals ordered by the doctor.

The diabetic who is out of bed

Probably the greatest percentage of diabetics one meets in hospital are those who have come to hospital to have their diabetes balanced. They may be new diabetics, or old diabetics who have for some reason become unbalanced. Diabetes is most satisfactorily controlled at this stage in the hospital, because supervision of the patient is much more adequate and the regular routine is helpful. As Dr. Allison mentioned, these patients should be allowed out of bed,

and allowed to exercise as much as possible while in hospital — thus a normal amount of activity is more nearly approached.

The hospital nurse's duties with respect to this type of patient may be considered as follows: administration of special diet; administration of insulin; collection of urine specimens; teaching the patient; recording diet, insulin, results of urinalysis, and blood sugar estimations.

In most hospitals, the *diabetic diets*, along with other special diets, are prepared in the diet kitchen, and sent to the ward ready to be heated and served. It is necessary for the nurse to know and to tell the patient that he is to eat *only* what is on his tray, and also that he is to eat all of the food that is served to him. Should the patient be unable to finish his food, the amount which he does not eat must be recorded. Once patients realize that their treatment depends upon their eating a measured amount of food, there is little difficulty about "cheating" on their diet. If friends bring fruit to the patient, the dietitian is usually very glad to fit it into the diet. Foods with no caloric value, such as clear tea and coffee, oxo, and chicken broth, may be given *ad lib*, and often a hot drink will satisfy the patient until the next meal. Dr. Allison mentioned that an evening lunch is served to diabetics on protamine zinc insulin to prevent early morning insulin shock, and the nurse must be certain that these evening diets are given—usually at 10 p.m. The diabetic diet of today is actually very similar to a normal diet, except that cake, pastry, candy, jam, ice cream, and other foods high in carbohydrates are not given. It is also attractive because it includes large quantities of fruit and vegetables.

Insulin administration is another important part of a nurse's work in caring for the diabetic in hospital. In most institutions the special insulin syringes, which make the measurement of insulin accurate and simple, are used. Otherwise the insulin is given as a regular hypodermic injection. Unfortunately, however, due to the fact that there are different insulin syringes on the market, and two types of insulin, mistakes in insulin administration are made. A nurse should always check her measured dose of insulin with another nurse before giving it to the patient. "Checking the dose" should include: showing the syringe containing the insulin along with the ticket for that dose, and the bottle from which the insulin was withdrawn.

Urine specimens are collected as the doctor orders. In most cases, an a.m., a.c. specimen and a 24-hour specimen are ordered, and in special cases a.c. and p.c. specimens are also desired. These specimens are examined for glucose and ketones only, and are very important in the balancing of the diabetic. Most patients can be shown how to save their urine in a Winchester, and to collect their own specimens when necessary, and should be given this responsibility where possible.

As with all patients, the keeping of a diabetic's chart is very important. Most hospitals have a special diabetic sheet, which is kept on the front of the chart, so the doctor may see at a glance what progress his patient is making. The following information should appear on this sheet: diet and date ordered; insulin — type and amount; glucose in urine — grams per 24 hours; blood sugar level; weight; urinary output.

Caring for himself at home

The instruction of a diabetic patient while in hospital should form a major part of the care which he is given, and should certainly not be started just the day before he goes home. In some institutions, regular classes are held for all diabetics who are able to attend and understand the instruction given. Since

a public health nurse's article is to follow this one, a brief outline only of what instruction should be given the diabetic in the hospital will be included here:

1. *Explanation of the disease*: Early in his stay in hospital, the patient should be told in simple language what the disease, diabetes mellitus, is, its causes, and an explanation of his symptoms.

2. *Diet*: As a rule the dietitian gives diabetic patients instruction about diet, including simple definitions of carbohydrates, fats, and proteins and calories. When he leaves the hospital he is given his individual diet sheet, with amounts of food expressed in household measurements.

3. *Insulin administration*: The diabetic patient should be taught to give himself insulin as soon as the doctor decides that he is going to require to take insulin regularly. After he has learned to give himself insulin, he should continue to do so as long as he is in the hospital—thus by the time he goes home it will not be a strange procedure for him. A set of home equipment — saucepan and spoon — should be used for boiling the syringe and needle, rather than teaching the patient to use hospital equipment which he will not use at home.

4. *Insulin shock and diabetic coma*: A simple explanation of these complications should be given, including their causes and symptoms, and the patient must be given careful instruction about what to do should they occur.

5. *Care of skin and feet*: The diabetic should be made aware of the fact that he does not have as much resistance to infection as the non-diabetic individual. Therefore, it is imperative for him to bathe regularly, and to keep his feet in particularly good condition.

6. *Urinalysis*: As Dr. Allison mentioned, the diabetic should know how to test his urine himself, at least for glucose, and he may be shown how to do this in hospital. The Benedict's test for sugar is simple, cheap, and reliable, but various commercial preparations are also satisfactory if the patient desires to use them.

In the above outline for the instruction a diabetic should receive in hospital, it is assumed that the patient is of average intelligence and able to look after himself. Where this is not the case, it is important to contact a member of the patient's family, or a friend who may be given the necessary instruction. In any case, the diabetic should not be the only person in the home who understands the disease, because if he becomes ill there may be no one who knows how to help him. One difficulty which is frequently encountered in teaching a patient to give himself insulin is that he is unable to read the numbers on the syringe. This may be overcome by fastening a brightly-coloured silk thread around the syringe at the proper mark. The thread will withstand boiling for some time.

There are so many aspects to consider in nursing the diabetic patient in hospital that one feels an article of this length can only point the way to nurses who are going to care for diabetic patients. May I once more emphasize that in the field of internal medicine there is no disease which a nurse should understand as well, and there is no disease which is more interesting, than diabetes mellitus.

Improved Techniques

Improved techniques reversed the ratio of deaths and survivals in abdominal injuries as compared with that of the last war. About 60 per cent of the casualties in the last war were fatal, while in this war 60 per cent of such casualties survived.

The so-called early nerve suture resulted in regeneration in 85 per cent of the cases in this war. Another notable accomplishment in this war has been the reduction in the mortality rate in the dangerous cases, or the head, chest and abdomen wounds, which is only half as high as during the last war.

—*News Notes No. 29*

The Diabetic — From a Public Health Viewpoint

ISOBELL BARRON

The public health nurse has a valuable contribution to make in dealing with the diabetic individual. The same fundamental requirements apply as in the care of any patient: skilful nursing; family instruction to secure proper care during the nurse's absence; systematic teaching of general health matters; sympathetic understanding to afford encouragement; and wise assistance with all factors contributing to the welfare of the patient. Our objective is control of the disease to enable a return to normal life, physically and emotionally.

With the present-day trend toward health education of the public, we find in many instances a fairly good understanding of the disease. A primary requisite for the nurse then is a very thorough knowledge of her subject, and an ability to impart information. Her methods of teaching must be adjusted to the individual situation with which she comes in contact.

Diabetes is all too frequently associated with gangrene, and amputation. Therefore let us consider one such case in view of the aforementioned principles.

Mr. B, sixty-seven years of age, was discharged from hospital seventy-two days after amputation of the right leg. The wound had not healed, leaving an open suppurating area of approximately two square inches. This required a daily dressing and was one reason for the visiting nurse being called. It was necessary for her to supervise the administration of sulfathiazole; also to designate and instruct one member of the family in insulin administration.

Although he has been a diabetic for years Mr. B had, until admission to hospital, relied solely upon diet for the control of the disease. It had not been possible to arrange for instruction in hospital, so the nurse selected Mrs. M, the married daughter, to give the insulin. Since she lived in the same house, matters were facilitated considerably. At first she insisted that she could not possibly "put a needle into anyone". Tact and persistence were necessary to persuade her otherwise, and within four visits she was cheerfully performing her part with excellent skill and pride. In the visits following she was taught to observe the patient's condition, to recognize danger signals, and to understand the need for a regulated plan for daily living.

To provide skilful nursing care for the stump, it was necessary to teach Mrs. B how to sterilize dressings. Absorbent and gauze were purchased by the family in economical, large-sized packages, and from these dressings were prepared. One gauze square, to be placed next to the wound, and several cotton pledgets for cleansing were placed inside the folded dressing. These were wrapped in old linen and sterilized in an oven at 350° F. To prevent scorching, a pan of water was placed under the bundles for the first half hour. It was then removed and at the end of one hour the dressings were thoroughly dry. When opened, the wrapping provided a sterile field. It took Mrs. B but a short time to prepare a week's supply of dressings. Other essentials were placed conveniently on a tray. Thus, to do the dressing a minimum of time was necessary on each visit. Besides this responsibility, Mrs. B. was encouraged to keep her husband comfortable and to care for the left heel (under the nurse's supervision) which, too, had become infected.

Family instruction was incorporated throughout and, indeed, formed a part of each visit. An explanation of diet regime was planned and given along with suggestions for variety. This provided

an excellent teaching opportunity to benefit the family as a whole.

Fresh air, cleanliness, and pleasant surroundings are of prime importance, and, fortunately, were all present in this instance.

By showing a genuine interest and sympathy, the nurse has managed to avert the possibility of this situation becoming a tiresome burden. Brief though the visits have been, the nurse has brought cheer into the home, and a good relationship has been established.

It has been explained to the family that their attitude toward his disability could greatly help the patient to acquire courage to face the world again. Mrs. B especially had to be cautioned that over-solicitousness and over-helpfulness might slow down her husband's recovery. By doing things for himself, even though awkwardly, our patient is rewarded with a feeling of accomplishment, a contributing factor important in his psychological adjustment.

Now that the stump wound is healing, Mr. B is looking forward to obtaining a new limb. At present he is able to be up and about on crutches, and ventures outdoors daily. It is to be expected that he may have falls and setbacks, but Mr. B appears to be able to adjust very well. Doubtless the insulin injections will be necessary for the rest of his life but they will not interfere with his return to normal living.

A Nurses' Home or Anybody's Home?

ELIZABETH K. McCANN

Six administrators, all directors of nursing in large, well-run hospitals in widely separated areas in Canada and the United States, paused for a moment one day recently and considered. A hospital superintendent fifteen hundred miles away had stirred their thoughts with a revolutionary question.

Do student nurses need a residence connected with the hospital or can they, like university students, live apart from the institution? What is your opinion and why?

That in essence was the purport of his telegram. One would anticipate, in reply, at least six widely varied answers based upon the practice and experience of those institutions. But the replies *endorsed unanimously* the need for a residence connected with the hospital. In fact, so in accord were their feelings that were it not for dates, postal marks and geography one would feel inclined to suspect collaboration.

In fairness to their broadmindedness it must be said that a slight case was built up for "living out". It was suggested that students could more closely parallel their own home living quarters, and would feel happier, more independent and enjoy greater personal freedom. This is a factor especially for the married student whose home and husband are nearby. Greater opportunities may be possible in some boarding houses for personal entertainment. It was felt also that students living out would develop a "concept of cost", a sense of values and an adjustment toward economic security through a sense of responsibility.

A typical nurses' residence.

Reprinted from the September, 1945, issue of The Canadian Hospital.

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It was suggested that, if overcrowding was the problem, the probationers possibly could live out in their preliminary term until the time when ward work and studies must be co-ordinated (usually in six to eight weeks).

Senior students who have become well adjusted to nursing work and hours of study might live out. It was noted at one school, however, that when this privilege was offered to students, not one had accepted. All preferred to remain within "the home".

What then does that long-established, seldom-questioned "Nurses' Home" offer? Why is it needed for students? What are the returns to the hospital?

Why a nurses' home?

The answer divides itself into two aspects—the practical and the esthetic. Under the *practical* aspect we consider: (a) Cost; (b) health and (c) transportation.

(a) *Cost*: The cost of maintaining students in homes or boarding houses throughout the community is not covered simply by granting a "board and room" allowance to the students concerned. The necessity of providing dressing rooms, locker space and resting facilities involves considerable expenditure of money. The budgetary implications involve an estimate of student services to determine adequate compensation. In many hospital districts rooms in homes nearby would be unsuitable at the low rate of rent at which a hospital residence room could be obtained. Providing transportation or granting a travelling allowance and even providing escort service for night staff would likely be required if satisfactory consideration is to be given to the student.

Meals, too, would be a problem unless the distance between hospital and nurses' rooms were negligible. Some provision for meals for night staff especially would involve an allowance for board away from the hospital.

(b) *Health*: The influence of separate residences upon the health of

the students was a problem recognized and dwelt upon by each of these directors. The average age of first-year student nurses, around nineteen years, is a time when good supervision is both needed and appreciated. Guidance in living independently, discipline for healthy living, protection from indiscretion and ignorance, can all be handled easily in a well-run "Nurses' Home". Good meals, carefully prepared and adequately supervised by dietitians, are assured. Adequate heat, plenty of hot water and *consistently* good living conditions can be assured in a nurses' residence; and the breakdowns in health—always the responsibility of the hospital—are more easily prevented and controlled. The tendency feared by our correspondents was that the student would attempt efforts beyond her capacity if permitted to carry on independently of the hospital. Too much social life, too little regular rest, inadequate or irregular diet, too much home responsibility (especially if tempted to keep house while taking the course) would not only undermine the student's own health but, through her fatigue and consequent inefficiency, undermine also the quality of service rendered to the patients under her care. As one principal put it, "fatigue of student nurses is more far-reaching than fatigue of other students since it is *dangerous* to patients".

Health problems cannot be passed over without mention of the unfortunate necessity for night shifts and broken hours along with what is sometimes a very heavy class program. Rest periods under these circumstances suffer serious interference, since most individuals prefer their own rooms to rest areas provided by the hospital.

One writer stated very frankly that supervision is essential since nineteen-year-olds constitute the age group with a very high incidence of tuberculosis.

Recreation, an important factor in the maintenance of health, will be dealt with under esthetic considerations.

"Mrs. Chase" goes to a party.

(c) *Transportation*: Transportation difficulties are a major problem. Overcrowding of cars, unsatisfactory, undependable service, limited public and prohibitive private facilities, seem in themselves a very strong argument against outside rooms. The administrative problems associated with transportation seem unending. For instance, the necessity for having nurses on call and available *at once* as needed, especially in operating rooms; the need for odd hour shifts necessitating travelling at irregular hours; the difficulty in paralleling the training of two students so that those living together could have the same ex-

Companionship through sports.

perience at the same time; the uncertainty, even, of day staff being consistently punctual; the interference and waste of off-duty study and recreational time due to the need of travelling away from the hospital (counting actual travel time plus the time for changing in and out of uniform); these are just some of the problems mentioned in this connection. Such a recital seems adequate proof of the desirability of having students live in residence.

The esthetic aspect

Finally we come to the esthetic aspect. This may seem inconsequential in a dollars-and-cents way of speaking, but in the minds of these astute individuals it weighs the balance very heavily towards students living in residence.

It is difficult to measure or price that intangible sense of *esprit de corps* which has, in these trying times, been a lifeline to superintendents of nursing. The loyalty of the graduates has been an important factor in maintaining service. Life in the nurses' residence allows a wide range of contact. Living together, enjoying group activities, exchanging ideas and developing tolerance contribute immeasurably to the spirit of the institution. Students themselves enjoy and appreciate the facilities available through a well-directed extra-curricular program such as can be established *within* a nurses' residence. (The need for travelling any distance results in poor participation.)

One of the finer aims in a nurse's training is the creation of a good citizen not only for a community but for the world. Through the unique contacts in a nurses' residence, the student develops a broad national and international point of view. Universities, too, seem to have recognized this vital force in character building, as the tendency now is towards more student residences on the campus.

Conclusion

It will be seen then that, from both the hospitals' and the nurses' point of view there are *more advantages than disadvantages in the maintenance of a nurses' residence.* Stability, uniformity, discipline and quality of service are all affected by where and how the nurses live.

Therefore, on the basis of six highly qualified and very decided opinions, we conclude that "The Home", in fact "Our Home", is far superior to "Anybody's Home".

New Microscope to Aid Fight Against Cancer

Hygeia, magazine published by the American Medical Association, reports that a microscope that makes a mosquito's windpipe look as big as a baseball bat has recently been installed in the National Cancer Institute at Bethesda, Md., a branch of the United States Public Health Service.

The new instrument operates on the electronic principle, weighs over a ton, costs $13,000 to build and can magnify an object 75,000 times, thus making it possible for scientists to peer into sub-microscopic worlds heretofore known only by solemn guesswork. Among other uses, the microscope will aid direct comparisons of diseased and healthy tissues in cancer research.

Moreover, it will show for the first time how disease-fighting organisms in the blood attack disease-producing viruses — an important contribution to determining the effectiveness of various methods of treating diseases like the common cold, influenza and infantile paralysis.

—*Health News Service*

The Care of the Premature Baby

ELVA M. HEWITT

Premature births rank as the most common cause of deaths occurring in the first few weeks of life. Therefore it is important if our mortality is to be lowered to: (1) prevent premature births by good prenatal supervision; (2) give skilled care and attention from the moment of birth to any baby born prematurely.

Premature babies are not necessarily weaklings, however, and provided they are born without congenital disease or defect and receive skilled attention from the first, they almost invariably reach the average normal standard of development within six or at any rate twelve months and suffer no lasting handicap.

The distinguishing characteristics of the premature baby in contrast to the normal full-term baby are due to its undeveloped state:

1. The undeveloped state of the nervous system, which is the principle cause of the premature baby's most important characteristic, that is, inability to maintain and regulate its own body temperature. Contributing to this is the fact that very little available fuel is stored in the body and also the absence of subcutaneous fat.
2. The sucking reflexes are also commonly feeble or absent.
3. The undeveloped state of the digestive system makes it difficult for the premature baby to deal satisfactorily with any food but breast milk.
4. The generally low grade of vitality and consequent liability to infection.

These characteristics belong in greater or less degree to all prematures. In addition, the heart, lungs, or other organs may be defective or too undeveloped to function properly, but this is not so in the majority of cases. All these features indicate that the premature baby is one who is not yet ready to deal successfully with the ordinary post-natal conditions. Consequently the principle underlying all treatments is to imitate prenatal conditions as far as possible by supplying:

1. Warmth, evenly regulated. The body temperature is apt to fall rapidly and dangerously below what is needed to sustain life, unless special steps are taken *directly the premature baby is born* to minimize the escape of heat.
2. Sufficient fluid and breast milk.
3. Rest and avoidance of shock and infection.

PRACTICAL DETAILS TO OBSERVE

Whenever possible everything needed for conserving and supplying heat should be in readiness before the baby is born. No matter where or how a premature baby is reared it must always be very carefully guarded against draughts, chilling and infection, to which it is much more susceptible than the full-term baby.

The cot or bassinette: Use a deep wicker basket lined with three thicknesses of material. The outside lining should be of cotton, next heavy brown paper, then a strip of woollen blanket or flannel. Heavy brown paper is excellent for keeping out draughts and should completely line sides and bottom of cot. Baby should be kept 4 to 6 inches below the level of the top of the cot to prevent undue loss of heat by too free circulation of air around the head and body. Place a light woollen blanket, about 40 inches by 70 inches, over the empty cot. This is the enveloping blanket which should be placed about 6 inches from the top of the cot. A small bed blanket will do for this purpose. On top of the blanket place a firm mat-

tress and over this a soft bran mattress. The bran mattress can be made at home. It requires 10 pounds of ordinary bran, which should be baked in the oven for an hour at a temperature of around 250°F., to sterilize it. Make a mattress cover the size of the cot from heavy factory cotton and fill it with the baked bran. The bran mattress has the advantage of being hygienic and inexpensive, and can easily be renewed and the cover boiled should it get soiled. Cover the mattress with a small blanket tucked in all around and over this place a narrow strip of rubber sheeting, covered by a slightly wider piece of blanket or flannel. When baby is placed in the cot take one side of the enveloping blanket and tuck it over baby under both mattresses. Do the same with the other side, turning up the foot neatly. This makes a complete envelope, preventing draughts.

To maintain body temperature, three hot water bottles with flannel covers should be placed one at each side, underneath the outer blanket and the third, between the bran and the firm mattress, with stopper ends towards the foot of the cot. The temperature of the side hot water bottles should be 140°F. and the one between the mattresses 160° to 180°F. This should maintain a "cradle heat" between 85° and 95°F. as ascertained by means of a dairy thermometer placed between the blanket and the baby's clothing. Gradually lower the artificial heat supply as the baby is able to regulate its own temperature. Premature babies should be handled as little as possible, but they should be turned from side to side regularly to prevent congestion of the lungs.

Temperature of room: Some authorities recommend that the temperature of a room for prematures should be kept between 75° to 80°F. but experience gained at Mothercraft Hospitals goes to show that prematures reared in rooms with the temperature around 65° F. show very little tendency to colds and bronchitis, as long as the baby's temperature is kept normal by external means. The warmth of the room must not be kept up at the expense of freshness as is so frequently the case. Warm, moist, muggy air is, of course, very enervating; neither should the air be unduly dry — a pan of water kept in the room, or damp cloths on the radiator, help in maintaining normal humidity.

Temperature of baby: If the rectal temperature is taken each time baby is fed, undue fluctuations of temperature can be prevented by regulating the hot water bottles. Few prematures survive if their temperature is allowed to fall appreciably below 96°F. Little apparent harm is done by a rise of the temperature, but there is no excuse for allowing overheating to take place. A fairly constant temperature of 98° to 99° F. can be assured by reasonable vigilance.

Toilet: The premature baby should not be bathed, but oiled all over with warm sterile oil. The baby should be re-oiled every other day. It is not advisable to give a sponge bath until a normal temperature is being maintained. The room and garments should be well warmed beforehand and oiling and dressing should be done as quickly as possible. Dawdling at any stage robs the baby of heat, saps its strength and resistance. Each time the diaper is changed the buttocks and adjacent parts should be well cleansed with oil.

Clothing: Baby should be dressed in woollen garments, wool being so much lighter and warmer than other materials. A soft nainsook or gauze vest should be used next to the skin to prevent irritation from wool; next, two open woollen shirts with sleeves; wrap baby in soft "flannel square" or nightingale and then in woollen shawl. This provides four thin layers of wool, without too much weight. Diapers made of several layers of soft butter muslin or gauze can be used. A soft woollen bonnet lined with gauze or cotton and woollen bootees would complete the clothing. All garments should be changed every

other day when baby is oiled. If the above garments are not in readiness, a wrapping of cotton wool, lined with gauze, may be used temporarily. A small piece of cotton wool under the armpits prevents soreness.

Prevention of infection: The premature baby is extremely susceptible to infection; therefore, no one suffering from any sort of infection, even a slight cold, should be allowed to care for the infant or to enter his room. Even a mild infection may prove fatal to the baby. For this reason, also, visitors should be excluded from the room in which the premature baby is placed. The baby should be oiled, fed and changed in his cot, and only taken out to be weighed. Weighing should be done with clothes on, then clothes weighed separately after oiling is completed. Subtract weight of clothes from total weight to obtain baby's weight.

Feeding: Nothing but boiled water or glucose solution should be given in the first twenty-four hours, then give diluted breast milk. To all babies, breast milk is valuable but never so essential as for premature babies. Every effort should be made to establish the mother's milk supply. Remember that every drop of milk expressed is precious to baby and even the smallest amount should be given along with a weak milk mixture to make up the total. If no breast milk is obtainable a very weak milk mixture should be used, strengthening it slowly as baby's digestive system will tolerate it. The doctor will write the order for the correct formula.

Colostrum: It resembles in its properties the blood serum from which baby derived nourishment before birth. It is rich in soluble protein and is readily and completely absorbed without taxing the baby's digestive system. It thus provides the perfect transition from prenatal to post-natal nourishment and is the perfect educative material for the baby's untried and extremely delicate digestive system. If unable to obtain breast milk from the baby's own mother, if possible, the milk of a healthy foster mother should be procured. There are very few cases where the mother's milk cannot be established by skilled hand expression or by use of the breast pump, every four hours, five times daily until the baby is able to go to the breast. Alternate hot and cold compresses are also very helpful in stimulating the flow of milk. There is no absolute rule as to when a premature baby should be given a trial at the breast, but usually not until it is at least four and a half pounds in weight and able to suck vigorously. Commence with one feeding daily at the breast and gradually increase the number of times until it is obtaining all feeds directly from the breast. Keep baby well protected to prevent any avoidable loss of heat in changing from the cot to the breast.

Infinite patience and watchfulness is needed on the part of the nurse in the feeding of the "prem". A nurse attempting for the first time to feed a delicate premature baby is bound to make serious mistakes, unless she has been carefully instructed and forewarned. Her first need is to realize the feeble response and the defective sucking and swallowing powers of the average baby born before his nervous and muscular system is properly developed. Different methods of feeding may have to be used, depending on the baby's ability to suck. For the premature who sucks feebly a pipette or eye dropper may be used, with 1-1/2 to 2 inches of soft rubber tubing on the end, or a Breck feeder. At first the nurse may not succeed in getting the baby to take more than a few drops but, working up carefully, the premature baby can generally be brought to take what is needed before long, that is, about three ounces of fluid per pound of body weight. On the whole, three-hourly feeding is best for prematures, with seven feeds daily. However, for some weeks it may be impossible to give enough fluid without

feeding every two hours. Feeding more often than two-hourly tends to cause exhaustion and the interval should be increased to two and a half-hourly as soon as the quantity is not far short of an ounce at a time. Where the sucking response is absent or feeble, tube feeding by means of a small funnel and soft rubber catheter may be carried out, but should not be continued any longer than necessary. Feeding a premature with a spoon is never advisable at any stage — the milk is liable to be given with a rush and cause choking.

The experience gained at the Mothercraft Hospitals over many years is, that when given care and attention, no premature baby capable of living and doing well would be lost, if breast milk is provided and all other details in good nursing care are carried out.

Fragments Towards a Nursing Mosaic

GRACE GILES, B.A.

It has been truly remarked that absolutely new ideas are very rare. My purpose is to present some thoughts based on my interpretation of the present-day situation in nursing and the hopes I have for the direction in which we shall travel.

What constitutes satisfactory education of the nurse? To what extent can we control our own affairs and yet cooperate fully towards the welfare of Canadians? How can the individual nurse be stimulated to work with and for her profession? These are some of the questions which engage our attention.

First we must give leadership to public opinion on nursing problems. An uninformed public is an uninterested public. For too long we have wrung our hands in the comparative privacy of our organization. Let us take the folks behind the scenes, as well as inviting them to gaze at us across a flower-banked stage on graduation day. Tell them of the predicament of hospitals anxious to improve conditions for student nurses but largely unable to do so because of lack of money. We can publicly admit that we cannot continue to expect able young women with a high school education to enter nursing schools to obtain their theoretical education during late afternoon or evening hours when tired doctors can find time to lecture after all have had a strenuous day's work. If truly informed the public will be ready to insist that there should be legislation to ensure not more than a forty-eight hour week, including class hours for all student nurses. If the advantages of licensing of all those who nurse the sick for hire are understood, the public will urge that this step be taken and will be fully aware of the importance of controlling the numbers prepared, through establishment of a central school for the training of practical nurses.

Would it not be well to present briefs on nursing to our provincial and dominion governments pointing out that nursing schools are as truly provincial and national in their scope as normal schools and universities? In advocating that nursing education should become a part of the provincial educational system we might recall some proposals from the *Survey of Nursing Education in Canada*. Dr. Weir suggested a Board of Nursing Control in each province — to be as autonomous and free from

political intervention as a university Board of Governors. It would be the responsibility of the Board to appoint such officers as the provincial directors of nursing and of public health nursing, the adviser or inspector of schools of nursing, and the director of placement service. Probably in some provinces several of these responsibilities might be carried by the same person. The provincial Council of Nursing elected annually by the nurses' association would act in an advisory capacity to the appointed officials. Later we might work towards the attainment of Dominion registration and other desirable objectives but we should concentrate now on the possibilities of provincial government assistance.

It is impractical in such brief space to attempt to discuss the type of preparation which may be provided in the independent school of nursing. There are already excellent examples which may be studied when nursing education in Canada is established on an independent basis. It is the writer's conviction that there should be one basic curriculum for all professional nurses. We can learn from the mistakes of others and avoid developing what an eminent American educationist in speaking of secondary school education in the United States has described as "the odious dichotomy which has existed between academic and vocational education". It is suggested that we should continue for the present to offer a three-year course but that the basic program should be completed in two and a half years in order that in the last six months the student may have the opportunity of selecting an elective. This additional experience might be in either practical or theoretical courses, depending on what the nurse plans to do.

Some possible immediate projects in nursing education might include giving batteries of tests to prospective student nurses. Ultimately, valid tests which will help reduce the "mortality rate" among student nurses may be developed. We can work toward more uniform entrance requirements. We can keep records of adequate clinical experience so that no nurse will be able to say on leaving her school of nursing that she has never seen a tonsil operation. Administrators in schools of nursing might well consider shorter hours of duty for instructors, thus giving recognition to the fact that they have to spend much time in off duty hours preparing for their classes.

Nursing school libraries receive too little attention. The plan might be tried of having a minimum basic supply of books in each school of nursing with a large common stock for rotation between several schools. Possibly one trained librarian might operate the whole system, while one member of staff in each smaller hospital might supervise the use of the books. Speaking of library facilities, would it not be helpful to have our *Canadian Nurse* journal indexed in the *Ontario Library Review* and the *Index Medicus*? As research in nursing and post-graduate work develops this will be of increasing service to nurses and those interested in nursing. "Suggestion boxes" in our hospitals and nurses' residences might invite ideas from many who are interested in nursing.

While the university schools of nursing have done a great deal in providing clinical courses it is suggested that more short courses of possibly two months, in administration or supervisory work, would be very helpful in meeting the present shortage in these fields. We should look also toward the provision of extension courses in post-graduate nursing.

There is need for broader understanding on the part of nurses themselves. We have talked in the past about the need for superannuation schemes for nurses but perhaps since our turn-over is so high we should be emphasizing government annuities and insurance policies. Are most nurses acquainted with the

health and welfare services and the cultural opportunities in their communities, other than in the small centres? Would not some "information committees" in our local organizations be well worthwhile? What about having local groups watch for articles on nursing in the various papers and journals? Any untrue or misleading statements should be challenged. Inviting student nurse representatives to alumnae and chapter meetings will help keep the graduate group alert. Providing mimeographed copies of annual committee reports is a practice which has much to commend it. With the increasing need for well-prepared nurses for highly specialized types of work, perhaps the nurses' association could give scholarships to some promising students, and thus have prepared personnel for important positions.

The development of Nurse Placement Service, ultimately to cover all nursing service to the public, has great possibilities both professionally and for improving our relationships with the public. If student nurses were interviewed before the completion of their training the counsellor could find out their interests and give them advice on how to work towards their goal as well as help them to find suitable positions. Job analyses and surveys will be helpful in placing the handicapped, in improving working and living conditions for nurses, and in numerous other ways. It should also be possible to work out plans for exchange of positions within a province and between provinces.

This brief presentation has been made in the hope that it may contribute something towards the general thinking and planning which is so necessary if nursing is to go forward, confident in the knowledge of service rendered in the wisest way.

One Year at Manitoba "U"

E. ELEANOR BRAY

Note: *The Canadian Nurse* of February, 1944, carried the story of a community project under the caption of Scholarships. This was presented by the chairman of the Scholarship Committee of the Brandon Graduate Nurses Association and told of the problem of raising funds to meet a desired objective. The initial and largest contribution was, of course, made by the Brandon Graduate Nurses Association; but the actual objective was reached after contacting other groups—the medical faculty of the Brandon General Hospital and service clubs in the city. This year marked the third scholarship project, successfully carried through by the original plan.

The article previously referred to spoke of our first scholarship student, Miss Eleanor Bray, who completed her course of studies at the University of Manitoba in May, 1944. Miss Bray has since held the position of science instructor in the School of Nursing, Brandon General Hospital.

The second scholarship student, Miss Audrey Jones, completed her studies in public health nursing at the University of Toronto in May of 1945, and has since been associated with the Dauphin Area Public Health Test Unit.

It was felt that the readers of *The Canadian Nurse* would be very interested to read Miss Bray's account of her year at the University of Manitoba.

—EVA G. MCNALLY

In attempting to give my impressions of university life for nurses and to answer the question "What did you acquire from your university post-graduate course?", I discover that it is difficult to be entirely objective. Obviously,

highlights of the course may be appreciated by many, merely tolerated by the remaining few; on the other hand, eager students assimilate every grain of information available. Then, too, in order to completely accomplish the objective of nursing education, opportunities must be sought to apply the principles in well-formulated plans and policies.

Registration Day at the University of Manitoba found us bursting with enthusiasm and anticipation one minute, the next filled with apprehension and doubts. Through it all, however, was the determination to make the grade with as few casualties to the ego as possible. Looking back on the post-graduate course in teaching and supervision, not a few, but many contributions were made to my personal, social, educational and professional life. Comparable to a series of delayed action bombs, explosions occur at unexpected intervals when the light bursts through to assist in the solution of difficult problems, months after the completion of the course. Probably one of the best aspects of university life for nurses is the contact with other students thus obtaining new and varied opinions, a greater perspective and, above all, renewed enthusiasm.

The first term began with a conference of the teaching and supervision section, to discuss methods of observation and evaluation for our program of field work. We visited the city hospitals, toured wards, observed classes and asked innumerable questions; the personnel were very co-operative and considerate. Lectures began in October and the professors appeared enthusiastic about including nurses in their courses. We were equally anxious to create interest and to maintain good grades as these points would probably influence the continuance of the School of Nursing.

Certain classes are always outstanding: in anatomy we soon learned to arrive early and to be well supplied with paper, coloured pencils, rulers, and erasers as the diagrams appeared and disappeared with startling rapidity — the agility of the professor was amazing to behold! In sociology, to complement the course, every Friday we presented essays which gradually became a weekly report of friends, clubs, churches, home-towns, adjusted to illustrate the required personalities, interactions or cultural patterns. It was very distressing to the author when two girls chose the same small town upon which to concentrate their efforts but nonetheless it was all interesting to us.

Though we majored in nursing subjects, psychology, sociology and general education provided a background upon which to silhouette our professional knowledge. In a well-balanced course, appreciations and attitudes are as important as the information and specific skills developed. Probably the courses in nursing education and sciences were most popular, if we may judge by the active discussion. However, all problems were, and are still, common. Though satisfactory solutions were not always forthcoming, there was no lack of advice and enthusiasm. The stimulating personality of the director and the keen interest of the class as a whole, together maintained the tempo throughout both terms.

Best of all, we experienced the "conditioned reflex" relative to books. I do not infer that graduates do not read, but I for one had neglected to add to my professional library since student days, though aware of the need. My reading speed increased appreciably, otherwise I would still be struggling over assignments and term papers. With the campus libraries at our disposal as well as the city libraries, it was beneficial indeed to spend "spares" browsing among those books for which we rarely have time in "real life". During our practice teaching period we were able to use the libraries of the schools of nursing in the hospitals.

"Practice teaching" was a long story by itself. My appetite was definitely affected which was indicative of great mental strain and stress; my muscle tonus was incapable of maintaining good posture. First I was afraid that I would fall down; then wished I would, so I could hide behind the desk. Strangely enough, I lived through my first class and many more, though not without considerable worry.

Transportation facilities provided by buses and streetcars afforded an opportunity for us to become more or less enlightened as to the reactions of the general public; conversations were never held in subdued tones and were amusing as well as remarkable. There were detailed reports on sundry subjects from "post-war Germany" to "capital punishment", then to "cheese-burgers" or "Hot-house Rose nail polish".

Although our days were very well occupied with lectures, laboratory periods, practice teaching and assignments still we were able to participate in many university social activities, beginning with the Freshmen's Day Program and the Co-ed Hike in September. After taking part in the novelty races, I soon discovered that my relationship to a wheel-barrow was remote and that two people can run much more efficiently with four not three legs — we had fun and we did not come in last. Pep rallies in the "Snack Shop", play and dances, not to mention the Convocation Day celebrations, contributed to our enjoyment. In addition to the university entertainments, our social committee planned dinners and social evenings within our own school. The Manitoba Association of Registered Nurses sponsored a dinner at which we were honoured guests.

As the pioneer class of the University of Manitoba School of Nursing, we acknowledged the privileges but realized also the responsibilities. The year of post-graduate study at the university indicated to us, that as well as having professional ability, the graduate nurse must acquire certain personal qualities, social interests and a sound education in order to compete with the rapid progress in other fields—industrial, educational and professional. Obviously these qualifications should be initiated in the undergraduate course but professional requirements, the long-standing incompatibility of nursing education and nursing service, predispose temporary postponement.

We must be prepared to assume civic as well as professional responsibilities in the community. The student nurse and later, the average graduate nurse, no matter how energetic she may be, invariably evades committee work in her community, being either "too busy" or "on duty". Though indirectly caused by long hours of study and ward experience, these excuses gradually place the nurse "on the edge" of civic activities and social responsibility. Consequently a tendency to remain in our "business" environment on and off duty develops. Let us plan to contribute to our community life and improve our relationship with the public to promote understanding and tolerance. Only in this way can we cope with rehabilitation problems in addition to the ever-present public health and hospital difficulties.

After one year of teaching, I continue to appreciate the advantages of post-graduate study — panel discussions, symposia, informal discussions, term papers, reading assignments. The reference material, properly filed, is invaluable. In forming faculty organizations, for graduates planning conferences and curricula, including students and subsidiary workers, it is beneficial to have information at hand or to know where material may be obtained. Even one year spent in the university environment develops an appreciation of the possibilities for nursing education, now and in the future, in order to better serve nurses, nursing associations and the nursing "public".

PUBLIC HEALTH NURSING

Contributed by the Public Health Section of the Canadian Nurses Association

Techniques of Interviewing

LILLIAN THOMSON

One summer evening in Alberta, a V.O.N. friend of mine took me home to dinner and, as we strolled along encumbered by groceries, I carried her little black bag. Arriving in the house my friend was just pulling off her hat when I dumped the bag on the floor. "Don't do that", she said quickly. "The bag has to stand on the table." I respected her attitude tremendously. I did not know in detail why the bag was precious for such knowledge would be useful only to nurses, but I felt that my friend displayed a sincere concern for the techniques of nursing. For professional techniques are not just so many smart tricks carried around in a conjuror's box. They can be a measure of our concern for the quality of our service, yes, and of our concern for the person served. The techniques of interviewing are exactly like that.

When a nurse tries to give any patient a chance to unravel some personal tangle through an interview certain general rules will smooth the way. To begin with, the surroundings should be such that there is freedom from distraction if possible. Has Miss MacDonald failed to persuade Mrs. Kenny to take Johnnie to the clinic? The explanation may be that the interview was broken off seven times because Johnnie demanded Mrs. Kenny's prolonged attention.

Secondly, the worker should school herself in the technique of sitting in a comfortable, relaxed position, for this is one way to get the patient to relax and chat. There is a lot to be said for the quiet hands of nuns.

Thirdly, a good interviewer listens far more than she speaks. The unskilled worker interrupts to give advice, to praise, to blame, to joke. The younger interviewer is especially prone to feel that she is no good unless she is handing out advice. She should try to overcome this unrealistic feeling. Considerable research has shown that while advice and admonition may lead to superficial changes in behaviour depending upon the authority involved, they will not of themselves give the insights by which personality is reshaped. Indeed, by throwing up defences they may block off insights.

Observation is the twin of listening. It is especially important in aiding children, because children have no means of explaining what is wrong except through the way they act. Marlene Devlin, aged six, is in her first week at school. "Marlene seems tense and shy", mutters her teacher. "That child looks sly", comments the music director. Miss Calhoun, school nurse, pauses at Marlene's card in her file. "She obeys quickly", she recalls, "but not cheerfully; she never smiles, and she doesn't speak to the other children. I must not forget about

Marlene." Miss Calhoun is observing carefully, avoiding snap judgments, and recognizing that the child may need help.

And what about questioning? Are enquiries about the progress of a disease any different from enquiries about a personal problem? The former are gladly accepted by the patient as indications of the nurse's intention to help. Questions on personal problems can indicate exactly the same thing. They should not reflect idle curiosity, prejudice, or a desire to punish a disliked patient. They should not wander into problems on which the patient has not requested aid. Miss Jones, an unmarried mother, applied for advice about nutrition and the interview failed to be constructive because the questions concerned the young woman's status and not her nutrition. An interviewer is almost sure to reveal by her manner what attitude prompts an enquiry. The question "How do you spend your Saturday nights?" addressed to the wife of an overseas soldier may convey either suspicion or kindly interest.

As a matter of fact, discussion of general rules for interviewing always leads to discussion of personality factors. Two personalities are involved in every interview because the nurse is not sitting apart like a film director watching two other people perform but she is herself one of the participants.

No one personal attribute in the interviewer will guarantee her skill in interviewing but there is one that will go twice as far as any other: an attitude of respect for the patient as a person. With this attitude even an inexperienced interviewer can give extensive help. I remember an interview between a young Travellers' Aid secretary and an old man who had run away from the Old Men's Home; how courteously the worker talked with him until he felt the beginnings of inclination to return of his own accord. If there were space here to record that interview many readers would say "Why, there's nothing to it! It's just common sense!" Yet in the hands of innumerable interviewers, three distinct errors would have been made: the old man would have been mentally labelled as a senile tramp; he would have been reproved jokingly or sharply for running away; his prompt return would have been arranged without his consent. Each error would have stemmed directly from a failure to respect the applicant as a person. Each would have resulted in the Home re-admitting a hostile old soul, more than ever determined to prove that he could make his way in the world if not interfered with by a lot of busybodies. Such are the destructive results of many interviews. To guard our respect for personality, at what points do we need special fortifications?

The hostile patient presents one such point. Miss Osler is interviewing Mrs. Simpson about returning to hospital for re-examination. Mrs. Simpson pulls the hospital to pieces, including the staff, the food, the equipment. Miss Osler may respond with a sharp defence of the hospital, or say "I didn't think you'd be like this with *me*, Mrs. Simpson," or she may say "I think I understand how you feel but could you tell me more about it?" Which response is calculated to help Mrs. Simpson to the best possible service? Smooth and reasonable comes the answer: the third response, because Mrs. Simpson may be afraid of re-examination or may hate the authority embodied in the hospital. But the third response is not always made, which means that there is no effort to get at the real reasons for Mrs. Simpson's hostility.

There is a second danger point. Every day we classify and pigeonhole people, thus undermining our conception of them as human beings first and foremost. With great finality we say that this or that unpleasant person is a Scot or a C.I.O. organizer or a Baptist so what can anyone do? This appalling

tendency to label people helps one feel superior to the herd. But just as it is undermining international goodwill and national unity, it will ruin professional competence wherever a person-to-person relationship is important.

But little Miss Wilson, busy as a bee, never gets mad at patients and never plays pigeonhole. But she does not get along very well with other nurses or with social workers. "What is that awful Miss MacMillan doing on *my* case?" she often wails. She is, of course, oppressively possessive. Most possessive workers are less obvious. Their resentment against teamwork takes the form of witty comment on their colleagues' mannerisms. But until a worker faces her own tendency to ownership of "her" cases she cannot help the patient develop his own plans freely, nor can she freely put in his way all the means of help which the community has provided while she persuades herself that she can give superior aid.

Then have emotional factors no place? Miss Elder does well in interviews with older women but feels she is losing out in contacts with younger ones. Tonight, playing bridge, she suddenly catches herself saying "I can't understand these girls chasing all around after their husbands in barracks. Why can't they stay home?" Miss Elder thoughtfully studies herself. A mature and successful nurse, she no longer has the slightest need for the support and companionship of men, and, therefore, had discounted the affectional needs and fears of Judy O'Grady. "I am like the student nurses who have no patience with old people" thinks Miss Elder soberly.

Every interviewer has her own peculiar allergy to some particular problem. Let us return to little Marlene Devlin on whom the school staff made a variety of observations. Marlene has been in school two months and the nurse, Miss Calhoun, at last faces Mrs. Devlin, a fierce-eyed woman who cruelly beats her daughter. Now our Miss Calhoun gets along well with many unusual people including even that unpredictable school dentist. But a cruel parent she cannot tolerate. She hates Mrs. Devlin and shows it. Every interviewer should honestly review her own past reactions and if she has shown a special intolerance toward a particular type of behaviour she should guard her interviewing at that point. This is not to say that an interviewer should have no personal convictions concerning behaviour. She may rightly consider certain conduct to be immoral, sinful, immature. But as an interviewer her sole objective is to meet the need that is indicated. In the Devlin situation, child protection is needed badly. A display of loathing will not meet this need but probably will retard appropriate arrangements. True enough, Miss Calhoun may not be able immediately to achieve anything but a ramrod self-discipline with which to repress her hatred. When she becomes more mature, however, she may surmise that Mrs. Devlin herself was once a wary and unchildlike six-year-old, already emotionally crippled by extraordinary pressures in her early home.

Finally, respect for persons and the honesty of a desire to help can be measured by the nurse's awareness of her own boundaries. Admittedly it is not always easy to know when a situation is beyond one's ability to help. Sometimes it depends on how deep are the roots of the problem. Mrs. Simpson, whom we discovered resisting re-admission to hospital, may be suffering from a recent fright about an operation and, if so, the nurse might successfully interpret the real situation to her. But her resistance may be curiously associated with a long-standing bitterness toward her husband. To help her, the nurse then turns to other agencies. But the nurse has to have confidence in these agencies. I have already confessed that the average social worker doesn't know much about the little black bag of her

V.O.N. colleagues and about the skills therein symbolized. Nurses must often feel the same way about social work. But neither group should act as if, since it doesn't know the ins and outs of the other's territory, there can't be much to know. The nurse whose activities are centred firmly in the patient will draw freely upon the resources of other professions and meet the incidental problems of co-operation with increasingly sound judgment.

Affiliation for Student Nurses in Psychiatry

A considerable part of the program at the convention of the Registered Nurses Association of Ontario in April, 1945, was given over to the discussion of the need for psychiatric nursing. At this time a plan was already underway for an elective affiliation for the Eastern part of Ontario, at the Kingston Mental Hospital. The stimulus that the convention gave facilitated the organization of this project.

Letters were sent to the superintendents of nurses of fourteen hospitals asking that the possibilities of a psychiatric affiliation be considered. A conference at the Ontario Hospital, Kingston, was arranged for June 7, so that the superintendents might have an opportunity for discussion and to see the living conditions under which the student nurse would live during a three-month affiliation period.

In preparation for the affiliation, the superintendent of nurses at the Ontario Hospital and the teaching staff prepared a curriculum. It was decided that the hospital could offer a three-month course, three times a year, in September, January and April. The affiliating students would be under the direct supervision of an Ontario Hospital graduate nurse with special training in teaching and supervision. An opportunity was given the superintendent of nurses and the supervisor to observe affiliation programs in other centres. At a staff meeting the proposed affiliation was outlined to the graduate nurses. Their response and suggestions were such that the superintendent was assured of ample co-operation in the new venture.

June the seventh proved to be a perfect summer day for the conference. The hospital itself has a beautiful location amidst spacious grounds, beside Lake Ontario. Fifteen superintendents and instructors were present. For many, this trip meant a whole day or more of their busy time. A tour of the residence, a view of the grounds, and a visit to the wards on which the students would be placed was arranged before the formal meeting. The group was welcomed by the superintendent of the hospital. The clinical psychiatrist and superintendent of nurses assisted in outlining the program. An opportunity was given for discussion. All were agreed on the value of adequate instruction in the care of mental patients. The difficulty that the superintendents saw was the fitting of the affiliation into an already crowded curriculum. It was decided that a formal application for the elective affiliation would be made to the Ontario Hospital.

To date nineteen students have enrolled for each three-month period. This represents seven schools of nursing. One school has made this affiliation basic for all its students. Other schools plan to enter at an early date. It is felt that the Ontario Hospital has prepared an excellent program. This affiliation will broaden the curriculum of the schools of the general hospitals. The progress of this affiliation will be followed with interest.

—DOROTHY G. RIDDELL.

Preview

The day is past when the infant with club feet was allowed to grow up into a crippled childhood. Even in corrective measures there has been a change in the past few years when the plaster casts gave way to the specially-devised Denis-Browne splints. Erma R. Erskine outlines the technique of applying these, her article being well-illustrated to show the various stages.

HOSPITALS & SCHOOLS of NURSING

Contributed by Hospital and School of Nursing Section of the C. N. A.

Pyloric Stenosis

PATRICIA RAYMOND

Quite often we hear the statement, "This infant has projectile vomiting. He must have pyloric stenosis — he requires instant operation." However, many factors must be taken into consideration. One of these factors, and perhaps the most significant, is that in Sweden, in some clinics, these infants are not operated on at all. The medical men prefer and have a great deal of success with the less spectacular but apparently effective medical treatment.

What, then, is pyloric stenosis? A stenosis is a contracting or shrinking of a duct or canal. In this instance it is a narrowing of the pylorus due to hypertrophy of the pyloric muscle. It occurs most commonly in first-born male infants of from two to ten weeks of age but may occur in any infant.

The pathological picture shows "an elongated, thickened pylorus resembling cartilage, the lumen occluded by the swelling of the mucous membrane, with hypertrophy of the circular fibres of muscle. The symptoms vary, but those most usually seen are projectile vomiting leading to rapid loss of weight, constipation or obstipation and a decrease in urinary output." Commonly, large peristaltic waves may be observed passing across the distended abdomen and a tumour, about the size of an olive, is palpable in the upper abdomen. Gastric retention may be established by gavage or x-ray.

Until the tumour is felt, operation is not undertaken in our hospital. If the tumour is not readily palpable, the infant is treated as in a pyloro-spasm. He is given atropine in doses of gr. 1/600 to 1/1000 as an antispasmodic, combined with phenobarbital, gr. 1/6 to gr. 1/8, as a sedative, half an hour before each feeding. The feedings are thickened, being either a cream of wheat formula or one thickened with barley. We may lavage immediately before each feeding to prevent gastric irritation. We sustain the infant by parenteral fluids until either the tumour is palpable or the baby is able to maintain his own fluid balance.

Once that small oval mass is felt, however, a different course of action is opened up. We prepare instantly for a pyloromyotomy, or Ramstedt operation, as it is usually called. The preparation for this type of operation consists of typing and cross-matching the blood for transfusion during the operation, lavaging the stomach immediately pre-operatively, and preparation of the area designated by the attending surgeon.

On the ward, pre-operatively, the nurse-in-charge is responsible for seeing that the lavaging is carried out, and that the infant is properly immobilized.

We tie him on to a padded, oiled silk-covered frame, fastening the left ankle down for the purpose of cutting down to the vein for the administration of intravenous fluids. These are usually started on the ward, 5 per cent glucose in normal saline or just normal saline being used. Then the infant is transported to the operating room.

Generally speaking, a local anesthetic is used, though occasionally a light whiff of ether is administered. During the operation the infant receives a constant transfusion.

On his return to the ward the nurses are prepared to carry out four standing orders. First, they take the infant off the frame, avoiding any undue exposure or chilling. Second, the baby is wrapped warmly, well propped on the side to prevent aspiration of any post-operative vomitus. Third, the arms and hands are restrained so that the hands and fingers cannot be sucked and air swallowed. Finally, the dressing is inspected for oozing. We prepare also for any untoward effects, such as respiratory difficulty. If there are any signs of this, the infant is rebreathed for one minute at intervals of five to ten minutes with a mixture of carbon dioxide 5 per cent with oxygen 95 per cent by means of an open funnel. This is continued until the infant's colour is good and respirations are more nearly normal, one to two hours generally sufficing.

Post-operative care from here on follows the routine observed for all operative cases, except in regard to feeding. The baby's fluid balance is maintained parenterally for twenty-four hours, with 5 per cent glucose and saline or with amigen, an amino-acid preparation, 5 per cent, if it is deemed necessary, depending upon his pre-operative condition. He is then offered oral feedings, starting with one dram of 5 per cent glucose saline which is increased by one dram every two hours until one ounce is reached. It is important to feed the infant on time; handle him carefully and as little as possible; avoid allowing any air to get into the nipple. We usually give the first few feedings through a rubber-tipped medicine dropper because the amounts are so small. When one ounce is reached, we add breast milk, a dram at a time, decreasing the glucose saline proportionately. As it has been difficult to obtain breast milk recently, we have substituted a light, skim, boiled milk formula with some success. Twenty-four hours post-operatively the infant's feeding chart should contain information something like this: 10 p.m., 5 per cent glucose and saline, drams 1; 12 p.m., 5 per cent glucose and saline, drams 2, etc.; until ounces 1 is reached; then breast milk, drams 1, 5 per cent glucose and saline, drams 7; and so on, until infant is receiving 1 ounce of breast milk. When this has been reached, we begin to add 2 drams of breast milk every two hours until the infant is receiving 2 ounces of breast milk. If this is well taken and retained, he is put on 3 ounces every three hours. Gradually, we resume his own formula.

The stitches are removed on the seventh day and he is ready for discharge by the ninth or tenth day.

We have had a great deal of success with our pyloric regime which includes expert medical attention and diagnosis, surgical treatment, and nursing care, the latter playing no small part in the pre- and post-operative care of a pyloromyotomy.

Preview

The renowned Lord Horder, able friend to nursing in Britain, wrote a strong appeal for a new deal in student nurse education. We are honoured to be able to bring this article in full to our readers through the courtesy of the London *Sunday Times*. It will appear in the forthcoming issue of the *Journal*.

GENERAL NURSING

Contributed by the General Nursing Section of the Canadian Nurses Association

Thiouracil

SARA BREHAUT *and* MILDRED THOMPSON

The thyroid gland controls nutrition, growth and body energy. This gland, which normally weighs less than one ounce, lies across the trachea. Though small, it can create a tremendous disturbance in the body when its function becomes upset. The use of a comparatively new drug, "Thiouracil" has, in many cases of toxic goitre, been of inestimable value, lessening the need for surgery.

The following case report is of interest in this connection: Mr. M, age twenty-seven years, was admitted to hospital on January 4, 1945. He had a history of irritability, nervousness, palpitation of the heart, throat filled with mucus, some dysphagia, fatigue and loss of weight. Admission weight was 132 pounds; temperature, normal; pulse (average) 90; blood pressure 160/90; red blood cell, white blood cell, hemoglobin and differential counts, normal; urinalysis, negative; cardiograph, no enlargement of heart, rhythm regular, some myocardial changes; basal metabolic rate, plus 24.

This patient's family history showed that a sister had died following a thyroidectomy, and that a brother was undergoing a similar operation in another hospital at the time of the patient's admission, so that he was very apprehensive towards surgery.

The following medication was ordered: Lugol's solution minims 10, three times a day. The basal metabolic rate continued to fluctuate from plus 24 to plus 35. Since this patient failed to respond to the usual regime of treatment, Lugol's solution was discontinued. On February 10, Thiouracil .1 gm., five doses daily, was prescribed. High vitamin, high caloric diet and extra vitamins in the form of Beminal Concentrate and Alphamettes were ordered.

Daily routine orders were set up which included: measure and record intake and output; record pulse before and after meals; laboratory check of the white blood count. This drug, like the sulphas, has been known to produce, usually within the first few days, a severe blood disturbance called agranulocytosis. If the white blood count decreases significantly, the drug is discontinued; urinalysis — twice a week to make sure the urine was free from red blood cells; check metabolic rate, neck measurements and weight once weekly.

One week later, Mr. M's basal metabolic rate was plus 19 and the same course of treatment was followed until February 25, when Thiouracil was reduced to .1 gm. four times a day, the clinical picture remaining the same. On March 20, Thiouracil was further reduced to .1 gm. three times a day. The

patient's nervous condition was becoming more stabilized and his outlook on life much brighter. On April 30, the basal reading was plus 2 with a gain in weight of thirty-two pounds and a gradual slowing down of the pulse rate. The patient was allowed to sit on the side of his bed and dangle his feet for fifteen minutes and Thiouracil was reduced to .1 gm. daily.

On May 19, Mr. M, having made steady progress toward recovery from thyrotoxicosis, was discharged having followed Thiouracil therapy for eighteen weeks. His clinical symptoms improved much more quickly than the basal metabolic rate, which reached normal slowly, being plus 4 on discharge. Mr. M was instructed to take moderate rest at home and to continue the medication in the same dosage.

Mr. M was re-admitted August 1 for a routine check-up. His basal reading at this time was minus 12 and he had lost ten pounds, but was feeling fine and carrying on a normal social life. Re-admitted to hospital on September 15, it was found that his basal metabolic rate was plus 14, with no loss in weight. He was discharged and directed to take Thiouracil .1 gm. every second day.

This patient, although not considered a cure, has shown marked improvement under another of our "wonder-drugs". (Thiouracil is sold under various trade names, for example, "Thyracil", a Frosst product.)

Streptomycin Production

Streptomycin, the new wonder sister drug to penicillin, is so difficult to obtain that the total output of the four companies now making it has been only fourteen ounces a month. Many requests are being received for the drug for use in the treatment of urinary and other infections caused by gram-negative bacteria which do not respond to penicillin, but these cannot be met. A gram, or 1,000,000 units, is the standard daily dose administered in three injections over a twenty-four hour period.

Production is limited severely because the drug is obtained from a natural fungus found in the soil and must be grown under carefully controlled laboratory conditions which cannot be hurried. The phenomenal production of penicillin which brought it from a laboratory curiosity to a commonly-used drug and the price from astronomical figures to about a dollar a dose was due in part to pressure of wartime needs. With the war ended and priorities a thing of the past, streptomycin does not have these advantages, thus working to some extent to hamper production, although industry is doing what it can do to supply the demand.

The principal uses are for treatment of soldiers with severed spinal cords who develop urinary tract infections because of a loss of bladder function, and to some extent in treating some cases of meningitis and other infections which do not respond readily to penicillin therapy.

—News Notes No. 29

Skin Irritation Tests

Suitable allergy tests to determine the extent of skin irritation caused by woollen clothing impregnated with insect repellent are to be conducted. One hundred and fifty soldiers who have volunteered for the test will be divided into three groups. Fifty will be equipped with untreated woollen uniforms, and will act as a control group. Another fifty will wear woollen clothing impregnated with a miticide preparation employing Tween-80 as an emulsifier. The uniforms of the third fifty will be impregnated with a miticide solution that uses tetrachlorethane as a solvent.

—News Notes No. 29

Nursing Education

Contributed by

COMMITTEE ON NURSING EDUCATION OF THE CANADIAN NURSES ASS'N.

Progress Report

This brief article is in the nature of a progress report on matters previously discussed on this Page:

C.N.A. Qualification in First Aid for Nurses

In October, 1945, *Journal* we noted that the Committee on Nursing Education had been asked to submit a plan and syllabus for a C.N.A. qualification in First Aid for nurses. The general conditions of such a plan were suggested in this previous article. The plan was prepared and submitted to the Executive Committee of the C.N.A. at its meeting in Montreal, November 29 to December 1, 1945. At this meeting a resolution was passed that the C.N.A. establish the First Aid qualification, and that recognition of it should be sought from appropriate groups (e.g., the nursing associations, the Canadian Medical Association, directors of nursing schools and hospital nursing services, the St. John Ambulance Association, the Canadian Red Cross, etc.). The plan has now been sent to the provincial associations and the provincial committees on nursing education for their comments and suggestions, after which it will be presented finally to the Canadian Nurses Association.

Accreditation

In September, 1945, the accreditation of schools of nursing was discussed in the *Journal*. At the recent executive meeting the Committee on Nursing Education recommended that the Canadian Nurses Association undertake the accrediting of schools which desired it. This recommendation was accepted by the Executive, who have undertaken to explore the means for financing this service.

Assistant Nurses

The position of the Canadian Nurses Association on this question has been stated again, as follows: "That, while maintaining the principle that full practice acts for graduate and assistant nurses should be obtained before the training of assistant nurses is actively encouraged, yet the C.N.A. would approve the training, or assistance in the training, according to approved standards, of assistant nurses, where this seems necessary and desirable in any province."

Preview

Does the nurse on the ward who industriously charts every detail of treatment and medication ever wonder what becomes of all of the pages of the patient's record when he is discharged? With hundreds, in some hospitals thousands, of patients receiving care in the course of a year, some method of handling and filing the cumulative records of each one is necessary. Frederick J. Fish has prepared a very interesting account of how this is done at the Vancouver General Hospital.

Announcing the 1946 Article Contest

In this issue, we are publishing the entry which won first place in our 1945 competition. The Editorial Board feels that this project is well worth repeating so has authorized the awarding of prizes during 1946 for the best articles submitted in our second contest. To give a wider group of nurses an opportunity to participate, it was decided to have two very different topics with a first prize of $25 and a second prize of $15 for each.

Suggestions for suitable topics were solicited from key nurses in various parts of Canada. From the subjects proposed, the Editorial Board has approved the following:

1. Bedside nursing—an essential service.

2. The integration of classroom and clinical teaching.

Let us conjure up a small group of nurses who might read this announcement and see how each might consider her experience a suitable background for writing. Mary Brown is a public health nurse. She is vastly concerned with the health of the school children, with the well-being of the infants and preschool children, with immunization clinics. She has done no bedside nursing since she completed her university course. It looks as if she would not be prepared to commit herself on either topic. Does Mary Brown not worry about small Jamie who has rheumatic fever, who needs nursing care in his own bed at home? If there is a Victorian Order nurse in that community, Jamie will get adequate service but if there is none, Mary Brown will be much concerned to see that proper care is given him. Bedside nursing—an essential service in truth.

Alice Green has served with the Victorian Order of Nurses for years. She is a firm believer in bedside nursing service in the home. But she does wish something could be done to limit the number of chronic cases she has to look after every week. Perhaps if she had some sort of nurse's aide who could give these bed baths it would leave her time free for the more acute cases. There are certainly possibilities for Alice Green to write in this contest.

Betty Black has been on the general staff in hospital ever since she completed her training. She is an authorty on the problems to be met in providing bedside nursing care. How can the nurse prevent it from becoming a more or less oppressive routine? Is it really an essential service demanding the best a nurse has to give? Every "Betty Black" in Canada can contribute opinions on this subject.

Turning to the other topic, there are some 175 schools of nursing in Canada, each with qualified instructors and most with clinical supervisors. How can the teaching program of the first group be most successfully integrated by the second group? Should the classroom teacher carry the clinical teaching for her subjects right into the wards? How may the head nurses most intelligently play their role in the integration of the student nurse's learning program?

With such interesting topics to write upon, it looks as if we should offer more prizes. However, let us have your entries and we will select capable judges who will make their choices on the bases of:

Soundness of opinions expressed.
Originality of ideas.
Clarity of thought.
Pertinence of any suggestions.
Ultimate value to nursing.

July 31, 1946, has been set as the closing date for this competition. Entries, marked "1946 Contest", may be submitted at any time prior to that date to the office of the editor of *The Canadian Nurse*, 522 Medical Arts Building, Montreal 25, P.Q. Six months ahead looks like a long time but the days speed by so quickly that July will be here before we know it. Get your entry written early so as not to miss out.

—M. E. K.

Notes from National Office

Contributed by GERTRUDE M. HALL

General Secretary, The Canadian Nurses Association

The Twenty-third General Meeting

Preparations are underway for the twenty-third Biennial Convention of the Canadian Nurses Association, which is to be held in Toronto, July 1 - 4, 1946 with headquarters at the Royal York Hotel. The general sessions will be held from July 1 to 4, inclusive; executive meetings will be held Friday and Saturday, June 28 and 29, and July 5 and 6.

The general sessions will be devoted largely to business and discussion of vital problem that are of such importance to the nursing profession at this time. Under the direction of Miss F. Munroe, president and chairman of the Program Committee, plans are being made to include all reports in the mimeographed folio. Reports will be taken as read, and time will not be required for discussion except for reports containing resolutions or controversial items.

On July 1 and 2 the entire afternoon programs will be given over to panels, which are being prepared on the following topics: (1) Nursing services in relation to community needs in general, followed by (2) Preparation of personnel to meet community nursing service needs. Special speakers are being invited to participate in these panels. Further details will be published in later issues of the *Journal*.

The Mary Agnes Snively Memorial lecture will be given following the banquet on Wednesday, July 3, and an outstanding speaker is being sought for this occasion. Local arrangements are in the capable hands of Miss Claribel McCorquodale, who is chairman of the Arrangements Committee. As hotel accommodation is limited to 120 rooms at the Royal York Hotel, reservations are being made for members of the executive and provincial delegates through the executive secretaries of provincial associations. When reservations have been completed for official delegates, other members will be accommodated. Watch for further information regarding this matter.

The educational exhibit is to be a feature of special value and interest to all nurses, and is being prepared under the guidance of Miss Claribel McCorquodale, in co-operation with the Cancer Foundation of the Ontario Government. Commercial exhibits will also be a feature of interest.

The responsibilities of the Canadian Nurses Association are becoming more extensive and varied with the passing of each year, and it is, therefore, most important that there be a full representation of official delegates from provincial associations of registered nurses. It is to be hoped that extra accommodation may yet be found to provide for as large an attendance of members as possible.

Executive Committee Meeting

A meeting of the Executive Committee of the Canadian Nurses Association was held in Montreal, at the Ritz-Carlton Hotel, on November 29, 30, and December 1. Those present in-

cluded: Miss F. Munroe, the president; Misses M. Lindeburgh, past president; R. Chittick, first vice-president; E. Cryderman, second vice-president; E. Mallory, honourary secretary; M. Jenkins, honourary treasurer; M. Batson, chairman, Hospital and School of Nursing Section; P. Brownell, chairman, General Nursing Section; H. McArthur, chairman, Public Health Section; E. K. Russell, chairman, Committee on Nursing Education. Councillors: Misses M. Myers, M. Murdoch (N.B.); R. MacDonald (N.S.); J. Masten, C. Livingston (Ont.); E. Flanagan, A. Girard, E. Killins, Sister D. Lefebvre (Que.); Mrs. D. Harrison (Sask.); Mlle J. Trudel, French associate; Miss G. Hall, general secretary, and Misses E. MacLennan and W. Cooke, assistant secretaries, C.N.A. Those present by invitation were: Misses M. Kerr, editor and business manager, *The Canadian Nurse;* A. Wright, executive secretary (B.C.); J. Dunning, registrar (N. S.); F. Walker, associate secretary (Ont.); F. Upton, executive secretary (Que.); E. Giroux, visitor to French schools (Que.); N. Fidler, vice-chairman, Committee on Nursing Education; E. Beith, convener, Labour Relations Committee; M. Mathewson, convener, History of Nursing Committee; E. Greenwood, Placement Service (Ont.); Mrs. C. Townsend, convener, Bursary Award Committee.

All provincial associations, with one exception, were represented at this meeting. The members were welcomed to the meeting by the president, on behalf of the Canadian Nurses Association.

Highlights of Reports

General Secretary's Report

For the purpose of studying administration, etc., the general and assistant secretaries visited the headquarters of the American Nurses' Association, the National League of Nursing Education, and the National Nursing Council for War Service from June 20 to 23. Many requests for information on nursing in Canada have been received from Great Britain. So numerous have these requests become that we have written a detailed article on the nursing situation in Canada, to appear in the nursing journals of Great Britain. National Office is now responsible for future activities of the Committee on Records.

Committee on Nursing Education

The special studies that are under consideration are as follows:
(a) A plan for a Canadian Nurses Association qualifications in first aid.
(b) The accrediting of schools of nursing in Canada. The following resolution was passed: "That the Canadian Nurses Association approve the principle of accreditation for schools of nursing in Canada, and that the Committee on Nursing Education be asked to initiate a plan of action as soon as possible."

Plan for first aid qualification for nurses: A minimum syllabus is to be prepared and sent to all schools of nursing in Canada. The instructor in each school of nursing shall be one of the regular nursing teaching staff, who must hold a first aid instructor's qualification (C.N.A., St. John Ambulance Association, or Red Cross). Examinations will be conducted by an Examining Board, to consist of three nurses and two doctors, these to be appointed by the Canadian Nurses Association. This Board will set and mark yearly examinations for the certificate, to be written by student nurses in their third year. Two local examiners (a doctor and a nurse) will be appointed, to whom the examinations will be sent. These local members will hold and mark the practical examination and return it to the Central Examining Board.

Outline of course: It is realized that in many schools some of this will be

taught in medical emergencies, surgical emergencies, and elsewhere. The material should all be given in the students' first year. Approximately six periods should be reserved in each of the second and third years for repetition, amplification and practice:

Lecture 1. Definition, need, obectives, responsibilities of first aider, examination, treatment and control.
Lecture 2. Shock—definition, causes, symptoms, prevention and treatment.
Lecture 3. Hemorrhage—definition, classification, symptoms, treatment, tourniquet.
Lecture 4. Wounds—definition, classification, objects, treatment.
Lecture 5. Bandages and slings—purposes, substitutes, general directions.
Lecture 6. Fractures—sprains—strains—dislocations—prevention, classification, signs and symptoms, treatment.
Lecture 7. Insensibility — causes, general rules for treatment.
Lecture 8. Resuscitation—artificial respiration.
Lecture 9. Burns — prevention, treatment.
Lecture 10. (a) Poisons (b) foreign bodies —symptoms, treatment.

National accreditation of schools of nursing in Canada: Accreditation of a school means judging the school upon the basis of the total pattern it presents, or upon the excellence of the school as a whole. Nursing organizations have been fully conscious of their responsibilities in bringing about needed reforms and have been working valiantly, through group activities, for many years to improve the efficiency of nursing service to the public. The next step seems to be to unite the efforts of schools through an accrediting organization, in working toward the ever-advancing goal of education for changing needs.

To the accrediting Committee would be given the task of setting standards for evaluation of nursing education and practice, of publishing a list of schools of acceptable standard, and of rendering whatever assistance may be possible to those schools which voluntarily seek recognition and identification with this activity. The growth of this project will depend, in part, upon normal processes of development, upon the values accruing from the service, and upon the education of the public to the useful place which this agency can fill.

Between this type of direction of professional education and control of professional practice by provincial registered nurses associations there are the following lines of demarcation: (a) educational standards of provincial registered nurses associations can advance only as fast as legislatures can be convinced of public needs and desires; (b) accreditation in the professional organization is entirely voluntary on the part of the school seeking it, whereas accreditation or registration of a school under provincial authority is coercive; (c) the standards of recognition in a professional agency are formulated by specialists who are well-grounded in their fields, while legislative enactments bearing on requirements for the registration of schools are often far below, or even contrary to, the demands made upon the profession.

What has been accomplished by members of our profession in the past, and what they are still doing to obtain laws based upon the best opinions of leaders in nursing education, are most commendable and deserving of the highest praise. We believe their hands could be strengthened by our national organizations, and this can be done best by a national accrediting agency, which will serve as a guide in provincial activities. There is no overlapping; each would serve independently of the other. The Accrediting Committee would study current needs and suggest plans, which would doubtless be considerably above provincial requirements. Provincial associations, if they accept the leadership of the Accrediting Committee, would encourage progressive schools to adopt the recommended pattern.

Purpose of accrediting: (1) To stimulate the improvement of nursing education by defining desirable standards for

nursing schools; (2) to assist prospective nursing students in selecting nursing schools, and to supply information to vocational guidance workers in high schools; (3) to get information which will be useful in educating professional and lay groups regarding nursing education; (4) to guide the provincial associations which are responsible for the standard of nursing education in each province.

Terms of accreditation: (1) C.N.A. accreditation will be on a voluntary basis; the school desiring this recognition will apply to be visited, and will pay the fee required for the work; this will be reviewed at intervals; an annual fee will be payable; (2) provisional accreditation will be granted to schools which would appear to be able to make certain improvements within a short period; (3) approval of a school may be withdrawn if the standards on which it was granted are not maintained, after a warning has been given.

Standards of accreditation: (1) organization; (2) school building; (3) teaching facilities; (4) teaching staff; (5) students; (6) curriculum; (7) records of the evaluation.

Sub-committee on subsidiary workers; It is noted that several provinces have drawn up plans for preparing these workers, and that experiments in their training have been carried out in Manitoba and Ontario. This sub-committee recommended that the Canadian Nurses Association again urge the provincial associations to take immediate steps to obtain Practice Acts in their respective provinces.

The following events have taken place in this field: (1) British Columbia has drawn up rules and regulations and duties for practical nurses who wish to join the Registry; (2) Manitoba has obtained the passage of an Act to provide for the training, examination, licensing, and regulation of practical nurses; (3) Ontario has submitted to the Minister of Health a plan for the administration of the training of practical nurses, a curriculum, and a request for licensing. So far, this submission has had no positive results.

SECTIONS

Hospital and School of Nursing: A copy of the plan concerning a Canadian Nurses Association qualification in first aid was sent to each provincial convener, asking for criticism and suggestions. A three-day institute is to be held in Vancouver early in 1946. In other provinces the following interesting studies and programs have been undertaken: (1) placement bureaux; (2) ward aides (advantages and disadvantages); (3) first year qualifying examinations; (4) reference reading lists; (5) standardization of nursing procedures; (6) refresher courses for supervisors and head nurses; (7) use of records for schools of nursing.

The Committee on Instruction has been studying the use of the face mask. Comprehensive reports have been received from two of the nine provinces.

General Nursing: A questionnaire was sent out regarding the private duty situation in each province. These replies show that, as in recent years, every effort has been made to provide all staff relief possible from members of this Section. Every effort is made to keep young nurses on staff duty. Reports across Canada show a definite shortage of nurses for private duty. Registries report a large increase in the number of unfilled calls. A form of "rationing" is in effect in all registries, priority being given to urgent house calls, and in filling calls from hospitals every effort is made to see that available nurses are sent to the seriously-ill patients. It appears almost impossible to make an equitable distribution, neither hospitals nor registries knowing in advance all requirements for the day, or the nurses who will be available.

Public Health: Quebec reports a newly-formed Industrial Nurses' Section, with the chairman invited to join the

executive of their Public Health Section. Alberta has had a successful institute for industrial nurses.

A project which is now underway by this Section is the compilation of the agencies, companies, etc., from whom public health nurses may secure posters and other illustrative devices for use in their work. This list when completed will be published in *The Canadian Nurse*.

National Bursary Award Committee

The convener of the national Bursary Award Committee reported a greater number of applicants, with superior qualifications — a more mature group than formerly. Unfortunately, the amount available from the government grant being considerably less than in 1944-45, a very limited number were granted bursaries. It was felt by the Committee that the profession was being deprived of better prepared nurses by this curtailment of the grant.

We can look for no further aid from the Federal Government. Education being a provincial concern, it would seem that the provincial associations would have to approach their own governments for future support.

British Nurses' Relief Fund

This Committee has assumed other responsibilities than those for which it was originally organized, as a result of a cable request from the League of Red Cross Societies to the International Council of Nurses, in connection with the promotion of a relief work program to assist nurses in the various devastated and occupied countries. The greatest need was for uniforms, shoes and stockings. A specific request was made that Canada should adopt The Netherlands. Consequently, an appeal for one thousand coats and five hundred capes was made to the provincial associations. (Permission was not granted for the purchase of uniform material, shoes or stockings.)

The first shipment left Canada on November 2 and the second shipment November 15. These shipments were made through the courtesy and co-operation of the Council of The Netherlands and his associates, and were addressed to the Netherlands Red Cross, The Hague, to be forwarded to Miss L. Van Hogendrop, chairman of the Netherlands Nurses' Association. It was necessary to follow this procedure in order to comply with free shipping requirements for relief supplies. Appreciation is extended to all who so ably assisted with this appeal to help the nurses of Europe. The total assets of this fund amount to $11,365.83.

History of Nursing Committee

The History of Nursing in Canada has been completed. The manuscript was presented by Mr. Gibbon for acceptance, as provided for in the recommendation approved by the Executive Committee in June, 1941. "Three Centuries of Canadian Nursing," as the history is to be called, runs into 150,000 words, approximately twice the length of an average novel. There will be a minimum of fifty pages of pictures. Every effort is being made to ensure publication at the earliest possible date.

We owe Mr. Gibbon a very deep debt of gratitude for the exhaustive study which he has made, and for his sympathetic portrayal of the development of nursing in Canada.

Labour Relations Committee

The following resolution, with reference to informing nurses as to the responsibility their professional associations could assume in assisting nurses in improving salaries and working conditions, was passed:

Whereas there is evidence of continued and increasing unrest among members of the nursing profession regarding working conditions, hours of work, remuneration, etc.; and whereas there is a great movement among labour unions to attract nurses to affiliate with these unions; and whereas despite the previous recommendations made by the national Labour Relations Committee that the provincial nurses associations set up active labour relations committees, there is still little understanding among individual members of the role the nurses' bodies are prepared to assume; be it resolved that the provinces be strongly urged to adopt an aggressive policy of seeking out and sponsoring every opportunity to meet with small and large groups of nurses, including staff meetings, to present the plans of the provincial registered nurses associations to assist nurses in securing satisfactory working conditions; moreover that, if necessary, a fully-informed nurse be especially delegated in each province to spend her full time in informing nurses of these matters, her salary to be taken care of by the provincial association as an emergency measure; and furthermore, that on matters relating to policy in labour relations, the national Committee be regarded as the steering committee, to integrate all the plans and policies formulated in the provinces.

Committee on Postwar Planning

The brochure was distributed to the nuring sisters, matrons, provincial secretaries of registered nurses associations, and to service counsellors. Replies received indicate that the information this brochure contained was most helpful. There are seventy-one nursing sisters enrolled at the nine university schools of nursing this term, and many plan to take advantage of the educational benefit in the future.

The following resolution from this Committee was passed by the Executive of the C.N.A., to be forwarded to the Federal Government:

Whereas the present capacity of University Schools of Nursing does not exceed six hundred and indications are that the request for post-graduate courses by nursing sisters will exceed this number; and whereas the nursing service needs in all fields of nursing are not being maintained; be it resolved that the Canadian Nurses Association request the Federal Government to give serious consideration to extending the period of time during which the veterans of the nursing services may take advantage of the rehabilitation grant.

The total number of nurses endorsed for UNRRA is seventy-five.

Report of Committee on Placement Bureaux

The convener reported on the institute on Placement and Counselling held in Winnipeg, Sept. 5-15, 1945. Four days were devoted to discussions of organizational and administrative matters under the leadership of Miss Hall. Dr. Frances O. Triggs, personnel consultant, American Nurses' Association, attended these sessions. Her contributions to the discussions were both provocative and constructive.

Special topics considered during the four days of conference were: objectives and functions of nurse placement service; criteria for selection of personnel, including staff education; preparation and use of reports and studies; cumulative biographical records; methods of coordinating placement service—provincially and nationally; public relations, advertising and publicity; occupational surveys; the special problems of the handicapped nurse.

As the conference developed, the potential value of placement service to nurses and to the public became more and more apparent. While consideration of each topic resulted in increased understanding and additional information, the discussions centred on functions, finance, and budgets, and occupational surveys were perhaps most productive. Methods and techniques of making occupational surveys were presented by Mrs. Laycock, supervisor, National Selective Service. She demonstrated their usefulness to

nursing by outlining a program for surveying nursing service needs in industry. She made many practical suggestions on sources of information and on the analysis and use of data obtained.

Dr. Triggs demonstrated a method of budget preparation based on proposed services and required facilities, a method which relates costs to the types and quality of service rendered.

While the agenda assigned the subject of functions to one session only, day by day a newer and broader concept of the functions of placement service took form; from this evolved a plan for a national placement service in which the work of national, provincial, and local bureaux would be closely co-ordinated and which would eventually provide nursing and allied services to every community, through community, district, provincial, and national offices.

The program of the second week was conducted by Dr. Triggs. These sessions were open to nurse administrators and were attended by a number of local members and a few from other provinces. The largest attendance at any session was thirty. The general theme of this part of the institute was Counselling and Personnel Practices. The nurses attending, particularly the placement service officers, took an active part. Objective tests, including general ability, nursing aptitude, preference and mental alertness, were administered, scored and discussed. Four panels were presented, each ably summed up by Dr. Triggs. The panel on Service Rating and Other Forms was chaired by Miss Pringle; Miss Wright led the panel on Interviewing; Miss Giles that on Job Analysis, and Miss Cogswell the panel on Personnel Practices. On Friday afternoon, Dr. Triggs reviewed the various phases of Counselling and placement which had been touched on during the preceding four days.

In addressing the first Institute on Hospital Personnel Management in New Haven, James A. Hamilton said, "We are here—not only for the enlargement of the mind, but for the development of a greater receptivity of spirit". Those who were privileged to attend the entire institute are immeasurably enriched. They came away humbled by a new awareness of the magnitude of the task we have commenced, but with a greater understanding of the broader services that can be rendered to nurses and to the public, and with a real conviction that these services can be made available We owe a great debt to Dr. Triggs and to the American Nurses Association, which made it possible for Dr. Triggs to come to Canada.

Report supplementary to report of institute for directors of placement bureaux: The core committee of the Committee on Placement Bureaux, C. N.A., met on October 11, at which meeting the proposed national-provincial-local plan for placement service was considered. It was then forwarded to the members-at-large for study and comment. In this report are included various data brought into the discussion at the meeting of the core committee. The report as a whole represents, in the opinion of the convener, the thinking of the Committee.

There are two main reasons why a discussion of such a co-ordinated plan is timely. One reason is that from the August Dominion-Provincial Conference came the proposal "to make available to the provincial governments grants for planning and organization so that each provincial government may, as soon as possible, establish a full-time planning staff to prepare for and organize health insurance benefits within the province". The second reason is the rapid development of placement bureaux in the provinces.

The Canadian Nurses Association, in a brief presented in June, 1942, included the following: "It is recommended that a nursing service be set up in the Regional Office with adequate professional and clerical staff to provide twenty-four hour service."

Clause 32 (2) (c) of the Provincial

Proposed Plan for Nurse Placement Service

National Plan-Eight-hour Service.	Provincial Plan-Eight-hour Service	Community or Local Plan-24-hour Service
Function	*Function*	*Function*
1. Referral from one province to another: (*a*) Nurses who register for positions not available within their province (*b*) Positions which cannot be filled within the province.	1. Placement of all referred nursing and related services, including subsidiary groups if and when legislation permits.	1. Compilation of credentials of all nursing and related groups in the community.
2. To serve upon request in a consultant capacity to provincial placement bureaux.	2. Referral to National Office: (*a*) Nurses who register for positions not available within their province. (*b*) Positions which cannot be filled within the province.	2. Placement of all registrants in the community.
3. To co-ordinate the work of provincial bureaux by developing uniformity in at least three special forms: (*a*) Reference blank. (*b*) Application blank. (*c*) Job vacancy.	3. (*a*) Reporting of inter-provincial transfers to National Office, such reports to include names. (*b*) Referral of credentials directly from one province to another of nurses who have transferred without notifying office, where credentials are in file, of change made.	3. Counselling: (*a*) with registrants (*b*) with employers.
4. Compilation of statistics from reports submitted by provinces.	4. Compilation of provincial statistics.	4. Referral to Provincial Office of registrants who register for positions not available within their community.
5. Preparation of material for use as a guide for placement and counselling publicity by the provinces.	5. Counselling: (*a*) with local registrars (*b*) with nurses.	5. Compilation of local statistics.
	6. Development of educational programs for registrants and employees.	6. Development of educational in-service and related programs.
	7. Promoting and maintaining good public relations.	7. Promoting and maintaining good public relations.

Services Rendered by Placement Bureaux

National plan

Service to Registrants

Referral of credentials to province or provinces where suitable positions are available.

Service to Employers

Referral of job vacancy form to province or provinces where suitable registrants are available.

Provincial plan

Service to Registrants

Placement and counselling:
(*a*) Registered nurses.
(*b*) Subsidiary workers.
(*c*) Allied workers.

Service to Employers

Counselling and referral of applicants:

(*a*) Hospitals special and general and allied institutions.
(*b*) Health organizations.
(*c*) Industry.
(*d*) Individuals and physicians.
(*e*) Medical clinics.
(*f*) Disaster service.

Community or Local plan

Service to Registrants

Placement and counselling:
(*a*) Registered nurses.
(*b*) Subsidiary workers.
(*c*) Allied workers.

Service to Employers

Counselling and referral of applicants:
(*a*) Hospitals special and general and allied institutions.
(*b*) Health organizations.
(*c*) Industry.
(*d*) Individuals and physicians.
(*e*) Medical clinics.
(*f*) Disaster service.

Service to Community

Telephone coverage to organizations and individuals:
(*a*) X-ray service.
(*b*) V.O.N.
(*c*) Automobile Ass'n.
(*d*) Druggists.
(*e*) Mortuaries.
(*f*) Children's Aid.

Supplying information regarding medical and health services available in the community.

Draft Health Insurance Act of 1943 contains the proposal "that as far as may be practicable, nursing service in each local area shall be provided through the local organizations which are representative of registered nurses, and that regard shall be had for the general qualifications, special training and experience, general ability and personality in assigning persons to render service whenever ordered."

In its presentation to the January, 1944, conference of Canadian Health Organizations, the Canadian Nurses Association stated:

> Bureaux and registries now exist, sponsored by nursing groups, to supply nursing service to the community through the placement of nurses. These are limited in number and function, largely due to lack of financial support. Under a health insurance scheme these bureaux should still be operated under nursing control with adequate financial support through the health insurance plan to meet more adequately the needs of the public. They should operate as adjustment agencies as well as placement bureaux.

The foregoing items indicate that the Canadian Nurses Association has informed governmental and health authorities of the need for an expansion of present placement service in a health insurance program and that the authorities who drew up the draft act recognize the responsibility of the nursing profession for the selection and assignment of nurses under health insurance. The next step, therefore, would seem to be the perfecting of a comprehensive plan designed to meet the total nursing service needs of the public, which would meet, as well, the professional counselling and placement needs of Canadian nurses.

The perfecting at this time of a plan, acceptable to both national and provincial associations, could, it would seem, guide the development of provincial services without setting too rigid a pattern. Provincial services must of necessity vary, as provincial health and medical care programs tend to show considerable differences. Co-ordination on a national level, however, would seem to be essential, in order that the movement of nurses from province to province may be facilitated, in the interests of our members and for the correction of present faulty distribution of nursing service.

In the proposed plan which is now presented for consideration, the functions of the national bureau are those of routing inter-provincial referrals and providing consultive and advisory services in matters of publicity, public relations, and general policy. Placement is not a function of the national bureau.

The following resolution was passed:

> That the Executive Committee, Canadian Nurses Association, approve the general principle of a national placement service and that the plan submitted by the Committee on Placement Bureaux be referred back to the provincial registered nurses associations following which suggestions can be made by the national Committee on Placement Bureaux as to possible immediate steps to be taken.

The provincial placement director is an itinerant officer, under whose direction the placement and counselling services within the province are coordinated and who is the inter-provincial and provincial-national referral agent.

The local bureau, which may be a community or district bureau, is the point at which a complete nursing service can be made available to the public and to which nurses may turn for vocational placement and counselling.

One feature of this plan would seem to call for careful and special study; that is, the proposed referral system, which would necessitate copying and distributing credentials. Widespread distribution of credentials might prove detrimental to the service; if employers knew that unfavourable reports would be copied and distributed, they would hesitate to be frank; if unfavourable reports were deleted when credentials were distributed, either within or outside the province, the prospective employer would not have the complete picture

he or she should have. This, however, is a problem for which the solution may be found within the general pattern of the plan.

It is recognized by the Committee that this plan is very ambitious; that its ultimate achievement will necessitate a large group of nurses with special preparation to staff national, provincial, and local offices and that, in relation to nursing associations' present resources, it is prohibitive in cost. It is felt, however, that some further expansion of present facilities is possible in the near future and that the introduction of provincial health insurance programs will hasten the achievement of a truly professional service in all communities and districts of our nation.

Publicity

The curtailment of the government grant has necessitated a curtailment in the recruiting activities. Projects already underway are being completed and when the material is "off the press" we shall announce it in the *Journal*. The scope of the publicity program was originally planned as an emergency measure, but it has been extended to include the broader field of public information and vocational guidance. The problems facing the nursing profession in the immediate future are many. We still need to attract the right type of young women to the profession; we need to make good nursing education available to them, and we need to maintain good relationships within the profession and for the profession. In the accomplishment of these ends, well-directed publicity can be of great value.

"Pattern for a Matron"

The Royal Victoria Hospital, Newcastle-on-Tyne, is advertising for a new matron. This is what its advertisement says:

The House Committee desire that this appointment should offer new opportunities to someone who is anxious to advance nursing practice and nursing education, and for these purposes have arranged to relieve the Matron of all duties within the hospital other than those directly related to nursing. She will be provided with adequate technical, educational, and secretarial staff. She will be encouraged to study in practice and by inquiry the nursing needs of the patient on the one hand and the needs of the nurses on the other, so that new methods and standards of nursing may be kept constantly in mind throughout the hospital. She will be given the opportunity of travel and of using all other means of keeping abreast of modern advances in nursing and of educational methods in other fields. The House Committee will welcome applications for this appointment from as wide a field as possible, including those who have not had recent nursing experience and from those with medical and other academic qualifications, and every opportunity will be given for applications from those who are at present in H.M. Forces. Terms and conditions of the appointment will be discussed at interview.—*Nursing Mirror, Dec.* 8, 1945.

The nurses of Canada will watch with keen interest the results of such an appointment, and we share the hope that the day is not too distant when the superintendents of nurses in Canada may receive similar consideration.

Annual Meeting in New Brunswick

The twenty-ninth annual meeting of the New Brunswick Association of Registered Nurses met in the Council Chamber, City Hall, Moncton, October 2 and 3, 1945, with the president, Miss Marion Myers, presiding at all sessions. Eighty-eight members were

present. Following the invocation prayer by Rev. Dr. Bryce D. Knott and the address of welcome by Deputy Mayor LeBlanc, Miss Myers introduced the special guest, Miss G. M. Hall, general secretary of the Canadian Nurses Association.

"It is with justifiable pride", said Miss Myers in the course of her presidential address, "that we see nursing recognized as a vital part of the social structure of our country, but let us not lose sight of the fact that such political economy as we are more and more adopting often demands control of essential services and nursing may yet be dispensed relative to public need. Nursing no longer belongs to us; it is a public utility of which the public has a right to demand its share. This brings us to the realization of the need to study the essentials which are fundamental to the preparation for nursing as we see members brought more and more into broader fields of expanding health services."

Areas mentioned as requiring study, and which would be given consideration during the session were: first year qualifying examinations, organization for practical nurses, and placement service.

The secretary-registrar, Miss Alma Law, reported a membership of 810 active, 340 non-resident, and 104 associate members.

Reports from Fredericton, Saint John, Moncton and St. Stephen Chapters showed growing interest and activity in various directions including special speakers at meetings, blood donor clinics, organization of registries, as well as local charity and goodwill activities and war work.

Tuesday afternoon, Miss Hall spoke at length of the challenges and problems of the immediate future and the gaps between present realities and future possibilities as revealed by some of the adjustments necessitated by the war. These included providing health service for returned service personnel equal to what they had had during the war; an integrated hospital system consisting of smaller hospitals radiating from key hospitals where all special services would be available; a body of nurses prepared for nursing of different levels of responsibility; and placement bureaux to take care of the distribution of nurses as required to meet the above needs. In order to bring about the services of which we dream, the most urgent need today is perhaps more general publicity, so that not only the general public but nurses themselves may understand and appreciate the goals for which we are working. She urged that chapters and small groups give serious consideration to studying the various questions and activities of the Association, for the responsibility rests with every nurse.

Professor Roy Fraser of Mount Allison University was guest speaker at the dinner meeting Tuesday evening. In his address, "The Future of Nursing", Prof. Fraser showed most unusual and sympathetic understanding of the thoughts, emotions and lives of nurses, and pointed out that the qualities required to adapt nursing to new conditions are inherent in the members of the profession as demonstrated by work already done, but warned that study of present conditions and perhaps willingness to give up some cherished traditions would be needed if we are to continue to guide our course from within the profession.

Wednesday noon the members were guests of the Moncton Chapter at a luncheon in the Masonic Hall. A very interesting talk on the customs and dress of the people of the different European countries was given by Mrs. Fred Sparling and illustrated by an exhibit of dolls in native costume.

A hobby show, with contributions from all parts of the province and set up by Moncton Chapter, attracted much attention. Outstanding in the show was a collection of ornaments, toys, and creatures of phantasy made from sea shells by Miss Atlanta Sollows.

Reports of Sections: Miss Muriel Hunter, chairman of the Public Health Section, reported that the number of public health nurses in the province is increasing. The 38 now active are distributed as follows: Department of Health, 11; services subsidized by the Department of Health, 2; Victorian Order of Nurses, 15; Saint John Board of Health, 6; miscellaneous specialized services, 4. During the year a mimeographed newsletter, *Public Health Round-up*, has been prepared and distributed quarterly among public health nurses.

Miss M. Murdoch, chairman of the Hospital and School of Nursing Section, reported that an institute for young staff nurses had been held in May financed by federal grant funds. Representatives from all schools of nursing attended. Some recommendations were made regarding first year qualifying examinations, also some changes in examinations for registration.

Reports of Committees: Representatives from the Legislation-Labour Relations Com-

mittee, of which Miss Dorothy Parsons was convener, had met with the Deputy Minister of Labour and some points not previously understood were clarified. The need for the Association having a bargaining agent was discussed and we were advised that, in the event of the need of such arising, which was unlikely, an agent could be obtained in relatively short time. We were advised not to name one until needed. Emphasis was put on the importance of having the status of nursing legally defined.

The Committee drew attention to the need for all nurses to keep themselves informed of policies and laws which might tend to relate not only to members of our group but which also have a far-reaching effect on life and social well-being of the country as a whole.

The report of the Publicity Committee showed that information regarding nursing and schools of nursing had been sent out in response to 80 enquiries, 50 per cent of which came on coupons from the pamphlet, Have You Got What it Takes to be a Nurse. Talks had been given to high school girls and appropriate films routed over theatre circuits.

The Nurse Placement Service Committee reported that a service had been inaugurated in October, 1944, with the set-up patterned after that of British Columbia. To date, 17 per cent of the active nurses have enrolled and data regarding their professional records has been assembled. Placements have been comparatively few as most of those who enrolled were not seeking immediate change in position. The requests for nurses far exceeded the number of nurses available. The director attended an institute in Winnipeg in September when organization of placement bureaux, and needs and methods of counselling were studied.

Representatives of the Subsidiary Nurse Committee met with representatives of the Maritime Hospital Council to discuss necessary procedure for obtaining legislation to license the practical nurse. On receiving the report of this meeting, the Executive Council of N.B.A.R.N. decided to first approach the group and try to assist them in obtaining legislation for themselves. A group of practical nurses in one city was found to be interested; they had already formed themselves into a "Club" with some attempts at regulations. To date this group has been unable to interest practical nurses in other parts of the province in organization. This report was followed by a panel discussion on the place of the practical nurse in the nursing program. The discussion, sponsored by the Saint John Chapter, created a great deal of interest and comment.

The Committee on Reconstruction gave the findings of a survey to learn the extent to which nursing needs were being met and to discover the number of active nurses in the various branches—private duty, public health, etc. Saint John Private Duty Registry had filled only 55 per cent of the calls received in 1944 and Moncton Registry 69 per cent. Less definite information was received from other areas but in practically all localities many calls were unfilled. The survey also disclosed that some sixty to seventy more nurses were needed for hospitals during the previous summer in order that satisfactory service might be given. The gap between the number of nurses now active and the number needed according to recent studies made in other countries and translated in terms of New Brunswick's population, was very, very great.

Resolutions passed at the meeting included the following:

1. That the war regulation regarding Courtesy Regulation be extended another year and that this be granted only to nurses who are returning to the profession and to married nurses who are travelling with their husbands and expect to be in the province less than a year.

2. That a committee of five be appointed to study the project of establishing provincial qualifying examinations for first year students, with Miss Myers as chairman and two representatives from sister hospitals and two representatives from lay hospitals.

3. That a period be set aside at the next annual meeting for the discussion of the resolutions and recommendations of this annual meeting dealing with matters of the Association.

ALMA F. LAW
Secretary-Registrar, N.B.A.R.N.

It has been estimated that the average nurse, on duty in a large ward, walks twelve to fifteen miles in the course of one day.

STUDENT NURSES PAGE

Religion in the Life of a Nurse

MARY MCLAUGHLIN

Student Nurse

University of Toronto School of Nursing

Religion can be a mighty moving river, or a stagnant swamp; a vital force or a dead form. I speak of the Christian religion. Christianity becomes dead when we concentrate on the periphery rather than on the centre; when we emphasize works at the expense of faith.

Griffith Thomas, in his book "Christianity is Christ", claims that "Christianity is the only religion in the world which rests on the Person of the Founder. A man can be a faithful Mohammedan without in the least concerning himself with the person of Mohammed. So also a man can be a true and faithful Buddhist without knowing anything whatever about Buddha. It is quite different with Christianity. Christianity is so inextricably bound up with Christ that our view of the Person of Christ involves and determines our view of Christianity."[1]

Nursing itself has had its roots in Christianity. Organized nursing dates back to the days of the early Church, when deaconesses were specially ordained by the bishop to tend the sick in their homes.[2] As we compare nursing today with this small beginning in the first century A.D., we see tremendous development. No longer does it form an organic part of the Church's life and activity, but is the concern of governments and private community organizations. With Florence Nightingale there was ushered in the new era of the nursing school and the trained nurse. Since the development of preventive medicine, public health has also been included within the nurse's sphere of action.

With the advance and increased complexity of civilization, the nursing profession has not stood still. As science has progressed, opening up many of nature's secrets, the nurse has sought wholeheartedly to co-operate with the doctor in the application of this knowledge, in bringing relief to a suffering humanity, in the prevention of disease and in the lengthening of the life span. A vast secular and humanitarian movement has sprung up.

What then is the relationship of Christianity to the nursing profession? All will agree that Christian ideals and principles have profoundly influenced its development. But are ideals and principles the essence of our religion? As Griffith Thomas has said, "Christianity cannot be separated from Christ. And it is our relationship to Him that counts."

I am a fourth year degree student at the University of Toronto School of Nursing. I have experienced all the benefits of modern methods in nursing education. But my training has not been an easy one. Coming from a year in medicine, I thought that nursing would

be a cinch. Little did I know what I was walking into. The crucial test was not in the absorption of knowledge, but rather in the outworking of character. Training in the profession I had chosen became a spiritual crisis.

I had been buried in books. Now I plunged into life. It was sink or swim; and I almost sank. There was deep agony of soul as the multitude of petty but ever-pressing duties loomed in frightening proportions. I struggled, but inadequately. I wanted to be a success, but found myself to be a dismal failure. Then, like Peter, I cried, "Lord, save me."[3] And He did.

Finally, I had discovered that life was indeed too much for me. Only in God could I meet its many claims. Only in Him could I alleviate even the physical needs of others, let alone their mental and spiritual needs. As I trusted Him for strength, the face of life was changed. I began to be happy in my work. Fear vanished and I was free.

If nursing is a Christian duty, then Christ must be our Head. Only in Him can the needs of the community be truly met. Only in Him can those true servants of humanity, the nurses of today, find the spiritual resources necessary for the adequate fulfilling of their daily task.

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2. Rom. XVI: 1, 2.
3. Matt. XIV: 30.

Obituaries

Mildred K. Crane passed away in Brooklyn, N. Y. Graduating from the Groves Memorial Hospital, Fergus, Ont. Miss Crane spent most of her professional life working in the United States. She was buried in the Grand Valley Cemetery.

Elizabeth A. Gillies died suddenly in London, Ont. A graduate of St. Catharines General and Marine Hospital in 1921, Miss Gillies was engaged as a supervisor in the Parkwood Hospital, London, at the time of her death.

Sarah Ellen McGuire passed away recently after an illness of five years. She graduated in 1922 from St. Michael's Hospital, Toronto, and served there as a private duty nurse until her health failed. Interment was in Owen Sound.

Bernice Outterson died recently in San Francisco. A 1915 graduate of the Montreal General Hospital, Miss Outterson went overseas in 1917 with No. 3, the McGill Unit of C.A.M.C. After service in France, she remained in England for some time before returning home. In 1921 she moved to San Francisco where she has been continuously engaged in private duty. Miss Outterson's funeral services were held in Montreal.

Ida Ovens, formerly of Campbellford, died very suddenly in Toronto.

Annie Loraine Wells died on Christmas Day after a year's illness. A native of Bracebridge, Ont., Miss Wells graduated from the North Bay Normal School and taught for several years before entering the Toronto Western Hospital to receive her nurse's training. After graduation she engaged in private duty nursing in Toronto.

Canadian Women's Club Helps

Three hundred nurses of the Royal Canadian Army Medical Corps were seconded, during the war, to the South African Army. The South African public liked them, took them to their hearts, and made friends with them. But to no group of people were they more welcome, and no group was more happy to have them in South Africa than the Canadian Women's Club of Johannesburg. That organization has just informed *The Canadian Nurse* that when an appeal reached it for contributions to the International Council of Nurses for supplies and equipment for the nurses of stricken European countries, it was glad to make a donation of fifty pounds to the I.C.N., on the condition that it be publicly acknowledged as a contribution in honour of the services of the Canadian nurses in South Africa during the war.

Kathleen Zwicker Grier, a 1926 graduate of the Royal Victoria Hospital, Montreal, is president of this active Canadian Women's Club.

Red Cross Scholarships in Manitoba

The Manitoba Division of the Canadian Red Cross Society offers a scholarship of $600, to be given each year for three years to nurses registered in the province who wish to take post-graduate courses in public health nursing at the University of Manitoba.

Essential Qualifications

1. The candidate must produce a letter from the director of the School of Nursing Education that she has met the requirements of the University for admission to the course in public health nursing.
2. She must give proof of personal aptitude for community service.
3. She must have at least a Grade XI standing with an average of 60 per cent.
4. She must be willing to sign a contract to serve under salary in the public health field in a rural community for a period of two years immediately following her graduation from the University.

The Manitoba Division of the Red Cross has asked the Bursary Award Committee of the Manitoba Association of Registered Nurses to recommend the candidate who will receive the scholarship.

For further information apply to: Commissioner R. N. Snyder, Manitoba Division, Canadian Red Cross Society, 31 Kennedy Street, Winnipeg.

Health Week

Benjamin Disraeli said that the health of the people is "really the foundation upon which all their happiness and all their powers as a State depend". In this connection it is interesting to note that today sickness, much of it preventable, is costing Canada, directly and indirectly, an estimated billion dollars annually — an appalling sum for a nation which appears destined to become one of the leading countries of the world.

To draw attention to this waste, economic and otherwise, the Health League of Canada, leading voluntary health education organization in the Dominion, designated the week of February 3 as "Health Week" — an observance dedicated to national, community, and personal health.

It is imperative that Canadians become and remain health conscious. The state of public health is steadily improving because of enor-

mous strides made in the field of preventive medicine, but even proven methods of prevention cannot succeed without the co-operation of the citizens at large.

For instance, milk-borne diseases still are common despite the fact that pasteurization, a simple procedure, removes harmful germs; and diphtheria is still taking a toll of Canadian children despite the fact that harmless toxoid is a proven preventive agent. These are just two instances, but there are still many citizens of this nation who continue to ignore the facts. Many do not seem to grasp the simple statement that "health is a priceless asset." It must be guarded continually through preventive and other commonsense methods if personal suffering, frustration, poverty, broken homes, and public relief are to be eliminated.

A special feature of "Health Week" was "Social Hygiene Day" on February 6. This day was set aside to draw attention to the fact that, despite all efforts of official and voluntary agencies, venereal diseases today constitute as serious a problem as ever. That there must be no easing in the fight against the VD menace is obvious.

—*Health League of Canada*

It's True!

It is true that more boys than girls, proportionately, have been born in war years, particularly in the years after a war, according to Dr. George Wolff, U. S. Children's Bureau statistician, but why it is true nobody knows.

Dr. Wolff advances several theories. It may be that the younger age of the mothers has something to do with it since in war periods more people get married and at a younger age. Or it may be the younger age of the father or some other biological reason.

Normally, the sex ratio is between 105 and 106 boys born for every 100 girls. In war years the sex ratio may go up to 107 or 108, a rise sufficient to have significance. Among Negroes in the United States, the differential is less than for whites, only about 102 boys being born for every 100 girls.

—*California's Health*

Letter to the Editor

Nursing in India

Editor's Note: We are indebted to Miss Kathleen Sanderson of Vancouver for forwarding to us Miss Eaton's descriptive account of nursing in India. She is a graduate of the Royal Victoria Hospital, Montreal, and has been with the Canadian Baptist Mission for about twenty years. Her special duty is the instruction of native student nurses.

We are not busy in the hospital. In fact we have seldom, in ten years, been so free of patients. There is good reason, for cholera has struck our village, as well as the district around about. And cholera is a fearful thing; a person may be strong and well in the morning and dead by evening, dying after a few hours of agony. So all are fearful and everyone who can stays closely at home No one will venture to go where they know it to be. Vuyyuru is being shunned at present, and only those who are desperately sick and have had to come, or those who are with us and too sick to leave, are still in hospital. But it has made us more aware of those who are here, and as we looked around we began to realize what a representative group they are and we thought you would like to know just what sort of folk come to us for help.

Anasuyya is a *Kamma*. Anyone acquainted with the people of the Kistna District thinks first of the Kammas, for they are the wealthy, land-owning people of this predominantly farming community and the most outstanding caste. And Anasuyya is a member of one of the most wealthy and well-known

families among them, but withal a gentle unassuming woman, literate and highly intelligent. These people are free of caste prejudice and disgusted with the priestly domination of the Brahmins; many seem to have no religious belief, though outwardly they are Hindus. Anasuyya is here for her confinement, her eighth, though she has only two little daughters living. Now the little son and heir is born and the whole family is jubilant.

Seetamma is a *Brahmin* and, as such, represents the highest caste in India, the priestly caste. But there is no caste to illness and disease. As the result of venereal infection she had had no children though she had been married for twelve years. But she has had treatment, has had a little son, and is just ready to go home. She has been staying for two months since he was born, in the choultry, or free hostel, connected with the hospital so that he might get a proper start in life. She came in smiling this morning, handed us four lovely oranges, saying, "My son is going away today so he brought you this fruit. Look at him and see if he is alright and fit to go."

Korteshvaramma is from the *Raju*, or warrior caste, second only to the Brahmin in the social scale of India. We do not have many of them in this district. They are a proud reserved folk, their women among the most strictly purdah of our women, less friend and harder to contact in the usual ways but grateful for the help we can give. Korteshvaramma was brought last night from a distant village, in a palanquin, the song of the bearers sounding far ahead of them, breaking the quiet of the night. She has puerperal sepsis, the cause of so much suffering among our women, due for the most part to lack of proper care. It is to provide this care that we are training nurses in our training schools to take their places in the plans that are being laid for better maternity work out in the villages.

Jayalukshmi was a darling little *Komaty* baby of three years of age. The Komaty caste is the merchant caste, and in these days of inflation and black markets they are credited with being even more well-to-do than they have always had the name of being. But the Komaties have been one of the most conservative elements of the country, and seem little touched by the modern ways of thinking, and so they cling to the native medicines, the charms and the potions that seem so out of keeping with their wealth and general status. Their child was so typical, loaded down with rings and bracelets, till we could hardly find room to feel her pulse, a heavy gold chain around her little neck, anklets weighing down the little swollen feet. She was gasping for breath, cyanosed, her lungs full. She had been treated for days with native medicines of all sorts so that we could not tell if she were suffering from disease or from treatment. The parents have lost all their other children, this was the last they had, and they hung over her anxiously, but they had brought her too late; we could not save her, she lived only a few hours, and they have gone out heart-broken.

In one of the private rooms is a *Kapu* woman. She would not have a private room by choice, for the Kapu caste are the poorer farmer caste, tenant farmers, working the lands of Brahmin or Kamma landlords, getting a share of the crop for their labour. But Lukshmikantamma has a very severe attack of tetanus and so she is isolated. Tetanus is very common in this country and very much dreaded by the people, as their usual methods of treatment are useless and so it is often fatal. As they have no understanding of infection they do not know the cause, and neglected wounds, in heavily infected ground, and the use of manure, in solution to surface the mud floors of their houses, give a very high incidence of the disease. The injections are very expensive for most of the people and the hospital often has to bear the burden; but these folk have been able to pay some of the cost themselves and she is recovering. The Kapu folk are humble folk, grateful for what we can do for them.

Wee Christina, in her cradle by the window in the maternity block, is a *Reddi*. At least, that is the caste in which she was born. The Reddi caste is one of the land-owning castes, very much like the Kammas, a bit less sophisticated, we think, and very lovely people to meet when they come to us as patients. They are keenly alive to the movements of the times, with a high level of literacy. Christina is an unwanted baby, born in the hospital. Her mother was brought here quietly by her parents. They left as soon as possible after the birth of the baby, proud folk, who were very concerned to

protect their daughter's name and that of their family. We will probably find a home for Christina with one of our Christian families who have no children of their own.

Fatmabi in the corner of the room there, keeping very much to herself, is a *Mohammedan* woman. The Mohammedans are a very small majority of the population here but, because we are a women's hospital, and these folk keep the women in purdah, we always have some of them with us. We cannot carry on a conversation with her for she speaks little Telegu; her language is Urdu, but she is grateful for help. She was hurt while riding in an oxcart. Her foot was caught in another cart as they were passing and the whole sole of her foot was torn off. She has had the stitches out now and will soon be leaving.

Veeramma represents quite a different group. She is a *Yeraka,* one of a wandering gypsy tribe who are constantly on the move, only settling down in one place for a few weeks, weaving baskets, raising pigs, and, so their reputation goes, engaging in petty pilfering. They are not the Lombardies, the real gypsies, who are in this country as they seem to be in all the world. The Yerakas are a purely Indian group, the men with wild uncombed hair, naked but for the flimsiest loin cloth, the women swarthy, primitive in their habits. We have difficulty in keeping them in hospital or in bed at all after their babies are born. They are a law unto themselves.

Lukshminarayanna is a *Dhobie* baby. He has dysentery and so is representative of a whole group of our little patients, for we always have half a dozen or so of these babies of all castes, desperately ill with dysentery because of the bad feeding habits and uncleanliness of milk and utensils. But Lukshminarayanna is a Dhobie, or washerman caste baby, a humble but independent class as become people who know they perform a very necessary task in the economy of the land. Their women are some of the most independent among Indian women, for they take their regular share in the support of the family and so are real factors in maintaining the family income. They are always clean and neat, even though their customers constantly claim that it is at their expense, for they can recognize their garments when the Dhobie or any of his family are out for a walk. After all when you have these clothes for a week or so it is quite an easy matter to borrow a few days' wear from each. If they are all washed again and returned to their owners in the required time, or even a few days late, what harm in that? So the Dhobies are a well-dressed, economically stable people, with a real, if lowly, place in the community.

Mariamma is one of our most valued *Christian workers,* a Bible woman from the Avanagadda Field. She has given a wonderful service in spite of a very frail body but recently she took an attack of malaria which broke down her very meagre reserve strength and she was brought to us very ill.

Samadhanam is a reminder to us of one of the saddest problems we have to meet, the heavy incidence of tuberculosis among our *Christian students.* She did not realize she was seriously ill at all. She had felt tired and weak but thought it was because she was studying too hard. She had failed in a couple of her examinations in teacher training and was trying to work them up privately, was prepared, and went to a nearby centre to write them off. While there she had a serious hemorrhage from her lungs. She is very worried, of course, as she is intelligent enough to recognize the symptoms, and we are only keeping her for a few days until we can see what plans she can make to go to a sanatorium. But T.B. is a heavy financial drain in this country where there are no free sanatoria to treat such cases and very likely what she gets will be inadequate because she will not feel she can stay long enough to benefit, and so another bright life will be cut off. We have this problem constantly presented to us and, so far, have no solution for it. We give the students in our schools and training schools a yearly examination as part of our medical service, and so are able to detect some cases when it is possible to help, but we are only touching the fringe of this problem. The incidence of T.B. is very high in all communities.

Nityanandam is one of our *Mission servants.* And what would we do without the servants? They make so many things possible in this country that otherwise we could not accomplish at all; a country where water must be hauled from the wells, food bargained for in the local bazaars, meals cooked over open fires, messages carried here and there in a land of no telephones. And Nityanandam is one of the best, a quiet depend-

able man, who is handy man around the school. But he was hurrying along in his work, stumbled, and was carried to the hospital with a broken knee cap. He had to have an operation for a radical repair and he will have to lie in his splint for another week or so, a hard job for an active man.

And so they come to us, and even as we write the cholera seems to be abating. They will have courage again in a day or so and come trouping in from every community, a real cross-section of the life of this great land.

—EVELYN EATON

Proposed Centenary Wing

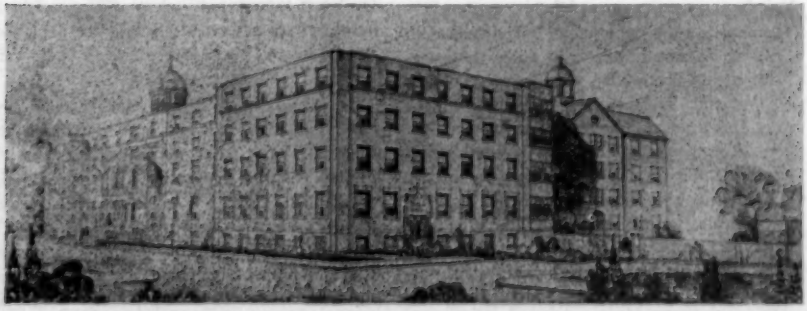
The Hotel Dieu Hospital of Kingston, Ontario, celebrated its Centenary Jubilee in September, 1945, marking its completion of one hundred years of charitable service to suffering humanity. It is a glorious record, duly honoured by members of the clergy and religious orders, who came from far and wide to pay tribute to the Religious Hospitallers of St. Joseph on this memorable occasion.

Myriad, indeed, were the tribulations and labours that mark the passage of time from September 2, 1845, when five Sisters of this Order arrived in Kingston to start a hospital in a small building with few conveniences and many disadvantages. Since that time many new buildings have been added and additions built. And now, to commemorate this milestone of one hundred years, funds have been raised for the future erection of a Centenary Wing for maternity and pediatric services.

The Jubilee festivities were opened on September 11, with His Grace, the Most Reverend J. A. O'Sullivan, D.D., Archbishop of Kingston, officiating at Pontifical High Mass in the chapel of the hospital. During the next three days the clergy, medical professions, citizens of Kingston, the Ladies' Auxiliary, and the graduate and student nurses were entertained at separate functions by Reverend Mother Breault and the Sisters. Guest speakers included: Reverend Alphonse Schwitalla, S.J., president of the Catholic Hospital Association of America; Major General Brock Chisholm, Deputy Minister of Health; Madame Pierre Casgrain of Montreal; Reverend Sister Helen Jarrell, R.H., B.Sc., A.M., Dean of Nursing, Loyola University, Chicago.

Although the hospital staff itself has now one hundred years of service behind it, it was not until 1912 that a training school for lay nurses was established. Graduates of this school have scattered to many parts of the globe, in all branches of the nursing field. Records show thirty-four graduates served with the armed forces of Canada and the United States in World War II. The Nurses' Alumnae was founded in 1920 and since that date has made valuable contributions to the education and social life of both graduate and student nurses.

On the final day of the Jubilee celebration



Proposed centenary wing of the Hotel Dieu in Kingston.

Reverend Mother Breault and the Sisters entertained the graduates and students at luncheon in the dining-room of the residence. Owing to distance, many of the graduates were unable to attend. Those of us who were privileged to be present felt it a great honour to be able to accept the Sisters' hospitality. We were most fortunate, too, in being given the opportunity to hear Reverend Sister Jarrell, who spoke eloquently of the necessity for higher education for graduate nurses and for skilfully trained personnel in the hospitals of the future, seeing in these means the only solution for maintaining the highest professional status of the graduate nurse in post-war reconstruction.

When the new Centenary Wing is built it is hoped that every graduate will contribute, in every way she may be able, to the furnishings, equipment, and adequate staffing of this monument of service. Let us strive, as graduates of St. Joseph's School of Nursing, to assist our hospital and, by so doing, to maintain to the fullest degree our school motto, "*Summum Semper Bonum*".

—ELIZABETH R. KIPKIE

Book Reviews

Public Health Nursing in Canada, by Florence H. M. Emory. 554 pages. Published by The Macmillan Co. of Canada Ltd., 70 Bond St., Toronto 2. 1st Ed. 1945. Price $3.00.

Reviewed by Jean E. Browne, National Director, Canadian Junior Red Cross, and Editor, "The Canadian Red Cross Junior".

Miss Florence Emory, the author of "Public Health Nursing in Canada", has won distinction for herself and the University of Toronto School of Nursing of which she is associate director, by filling a conspicuous need in available literature on public health nursing and public health administration. Miss Emory's book is the first to be published on these topics in Canada. The masterly presentation of material, the logical sequence in the development of her topic, and the cohesion of the text as a whole give no indication of the fact that this is Miss Emory's first published work.

This book is written with the sure touch of an experienced person with both knowledge and wisdom. It is therefore invaluable as a text for the public health nurse-in-training, and as a reference for the public health nurse in the field.

"Public Health Nursing in Canada" has the essential quality of good books in general — a sound basis of selection. It is — to use a favourite phrase of Stephen Leacock's — "undated stuff." The practical value of the book is greatly increased by the concise summary and the list of references at the end of each chapter. The bibliography is indicative of the diversified and extensive reading of the author in preparation for her undertaking.

Miss Emory's writing is contained in Part I. This deals with professional background, the function of the public health nurse, her preparation, the organization and administration under which she will work, programs of work both official and voluntary, supervision, records, nursing education, the organized profession, national health insurance, and the future outlook.

It is altogether typical of the objective attitude of this author that she should ask several specialists to collaborate with her in the production of her book. Part II is devoted to articles on Visiting Nursing, Maternal Hygiene, Child Hygiene, Communicable Diseases, Industrial Hygiene, and the Public Health Nurse as Liaison Between the Hospital and the Community, written by public health nurses who have had many years of experience in these special fields. In Part II there is also a chapter on Mental Hygiene by Samuel R. Lay-

cock, Professor of Educational Psychology, College of Education, University of Saskatchewan. This chapter is brilliant in its simplicity. Mental Hygiene indeed ceases to be the exclusive specialty of psychiatrists when reduced to its vital elements by Dr. Laycock. "An individual," says Dr. Laycock, "has the highest degree of mental health, therefore, when he finds rich and adequate fulfilment for all his needs in ways which serve and help rather than injure his fellow-men."

Although the author has had to explore the recent past to trace the development of public health nursing, her emphasis throughout is on present needs and future developments. The chapter entitled "The Future: Adjustments to Inevitable Change" reveals in her own words a "flexibility of outlook" which is typical of the work as a whole. In this chapter the question is raised as to the basic training of the public health nurse. The author suggests the necessity of research to determine for how long the preparation for this field will continue to be conditioned by a basic training with a pronounced curative emphasis.

The last section of Miss Emory's book is a spiritual interpretation of the work of the public health nurse expressed with deep conviction and beauty. She reaches her greatest height in the last paragraph: "To believe that the ultimate purposes of life are planned and controlled by the Eternal and to view her task as a contribution to the progress of creation towards its goal, is to harness professional knowledge and skill to the chariots of God."

An Introduction to Medical Science, by William Boyd, M.D. 366 pages. Published by Lea & Febiger, Philadelphia. Canadian agents: The Macmillan Co. of Canada Ltd., 70 Bond St., Toronto 2. 3rd Ed. 1945. Illustrated. Price $4.00.

Designed primarily to assist the student nurse to become quickly and readily oriented in the somewhat bewildering maze of new subject matter to which she is introduced, this text, now in its third edition, will be of great assistance. As the title suggests, this is only a form of introduction and no individual diseases are exhaustively discussed. However, there is sufficient descriptive material to form a sound basis to which the more detailed instruction would later be added.

In Part I, under the heading of "Some General Principles", Dr. Boyd has sketched briefly the evolution of medical science, then goes on to an explanation of the nature and causes of disease. Concise definitions are given to the many new words and terms as they are used. There is no glossary which might have aided the student in remembering the unfamiliar vocabulary. The results of circulatory disturbances and of nutritional deficiencies, the action of bacteria and some of the parasites, and a whole chapter on tumours, complete the first section. Part II discusses the various organs of the body and the diseases occurring in them most commonly. The study of anatomy and physiology is correlated in a brief outline of structure and function in each chapter. A simple statement of the usual forms of treatment, including nursing care, is outlined for each disease condition. Suitable illustrations help to explain the textual content.

Part III is relatively short, consisting of further details on the prevention of disease, the principles of treatment, and the usefulness of the laboratory.

Dr. Boyd is professor of pathology and bacteriology at the University of Toronto.

On Education, by Sir Richard Livingstone. Contains two books—"The Future in Education" and "Education for a World Adrift". 158 pages. Published by The Macmillan Co. of Canada Ltd., 70 Bond St., Toronto 2. 1944. Price (cloth) $1.75.

Reviewed by Harriette S. Wilson, public health nurse, Kitchener, Ont.

This would be a valuable book for all who are interested in broader education. Nurses should, of course, keep up-to-date with developments in the nursing world and also in their special field, but it is

a good thing to see where this fits into the whole world of education. We do not want to become like the specialist "who knows more and more about less and less until he knows everything about nothing".

The author is a firm believer in adult education and quotes from Plato, Aristotle, and Pericles to prove his points. To really get the most out of this book one should have a note-book and pencil handy so that notes may be made of the outstanding points. I should like to quote freely from the book but in a brief space will give such excerpts as will show the general trend:

"The pressing problem is to give the masses of the nation some higher education, which will include that study of human ideals and achievement which we call literature, history and politics, and that study of the material universe which we call science".

"For full appreciation and the most fruitful study of the subjects in question—history, literature and politics—experience of life is necessary".

"The cross-fertilization of theory and experience".

"Theory and practice illuminate each other".

"One of the great problems of the age, the problem of how to keep the middle-aged young".

"To treat disease one must diagnose its cause, and the diagnosis of our disease is not difficult. It is a sickness of the spirit".

"Christianity and Hellenism are the spiritual basis of our civilization".

Victorian Order of Nurses for Canada

The following are the staff appointments to, transfers, and resignations from the Victorian Order of Nurses for Canada:

The following nurses have been appointed to the Vancouver staff: *Eileen Sheffer* (St. Paul's Hospital, Saskatoon; B.Sc. in public health nursing, St. Louis University, Mo.); *Janet Wolverton* (Royal Columbian Hospital, New Westminster) and *Elizabeth Jenkens* (Vancouver General Hospital). Both nurses are graduates in public health nursing from the University of British Columbia.

Marion Joy Robinson (University of Toronto School of Nursing) and *Mrs. Billie Grainger* (Victoria Hospital, London, Ont.; B.Sc.N. University of Western Ontario) have been appointed to the York Township staff.

Helen Saunders, previously nurse-in-charge of the Walkerton Branch, has been appointed assistant district superintendent of the Border Cities Branch.

Marianne Coleman (St. Joseph's School of Nursing, London, Ont. and public health nursing course, University of Western Ontario), previously employed on the London staff, has returned to the Order and is on the staff of the Galt Branch.

Phyllis Scouler (Vancouver General Hospital and public health nursing course, University of B.C.) has been appointed to the Regina staff.

Elicsabet Janzen (Kitchener-Waterloo Hospital and public health nursing course, University of Western Ontario) has been appointed to the Sudbury staff.

Joan Stock (Ottawa General Hospital and public health nursing course, University of Ottawa) has been appointed to the Ottawa staff.

Harriet (Broad) Rainsforth (Victoria Hospital, London, and public health nursing course, University of Western Ontario), previously on the staff in York Township, has returned to the Order to take charge of the branch in Trail, B.C.

Gladys M. Doran and *Irene Sheasby* (Holy Cross Hospital, Calgary), having completed a two months' period of orientation introductory to Victorian Order nursing on the Toronto staff, have been posted to the Chatham and Sarnia staffs respectively.

Faye Saunders and *Margaret Holder*, who

were on leave of absence with scholarships from the V.O.N., were appointed, on the completion of their public health nursing course, as nurse-in-charge of the Digby and Amherst Branches respectively.

Mrs. Ada Murphy (Nova Scotia Hospital Dartmouth, N.S.) has been temporarily appointed nurse-in-charge of the Wolfville Branch.

Mrs. Ruth Abel, previously on the Toronto staff, has been appointed to the London staff.

The following nurses have been appointed to the Montreal staff: *Mary (Edwards) Hargraves* (University of Alberta Hospital, Edmonton; B.Sc. in public health nursing); *Beatrice (Heifetz) Wolfson* (Winnipeg General Hospital and public health nursing course, University of Manitoba); *Marguerite Bergeron* (Ottawa General Hospital and public health nursing course, McGill University).

The following nurses have recently been transferred: *Jeanette McInnis* from the Montreal staff to the Peterborough staff; *Lois Croft* from the Pictou staff to the Brantford staff; *Ruth Taylor* from the Calgary Branch to the Woodstock (Ont.) Branch as nurse-in-charge; *Blanche Rickard* from the Leamington Branch to the Calgary Branch as nurse-in-charge; *Nina Sage* from the Edmonton staff to the Surrey Branch as nurse-in-charge; *Helen Voss* from the Sarnia staff to the Leamington Branch as nurse-in-charge; *Florence Rand* from the Halifax staff to the Canso Branch as nurse-in-charge.

The following nurses have resigned from various branches to be married: *Margaret P. Smith* from the Woodstock (N.B.) staff; *Margaret Elwood* from the Border Cities staff; *Allison Mann* and *Janet Fleck* from the Vancouver staff; *Frances Scoville* from the Ottawa staff.

The following nurses have resigned to join their husbands: *Dorothy (Campbell) Wilson* from the Cornwall staff; *Phyllis (Boden) Nordman* from the Surrey staff; *Georgina (Carr) Guppy* from the Woodstock (Ont.) staff; *Katherine Ramsden* from the Vancouver staff; *Mary L. (Thomas) Patten* from the London staff; *Margaret (Beard) Guild and Anna (Chumak) Cobell* from the Toronto staff.

The following resignations have recently taken place: *Florence Greenaway* as assistant district superintendent of the Border Cities Branch to accept a position with the Toronto Western Hospital; *Irene Martin, Inez MacDougall* and *Doris M. Jackson* from the Vancouver staff to take up other work; *Kathleen Forrest* and *Laura Fraser* from the Victoria staff, the latter to accept a position with the Victoria Department of Health; *Marjorie Beck* from the Toronto staff to accept a position with the Grace Hospital, Toronto; *Lucienne Rousseau* from the Lachine staff to accept a position with the Department of Health in Montreal; *Mary R. Hill* from the Canso Branch to return to her home; *Jean Hill* from the Sackville Branch to take up other work.

The following nurses, having completed a two months' period of supervision introductory to Victorian Order nursing on the Montreal staff, have been posted as follows: *Ellen Pocock*, North York Branch; *Frona Carr*, York Township Branch; *Edna Knutson*, Timmins Branch; *Marion Hellyer*, Kingston Branch.

Dorothy Paulin has been transferred from the Trail (B.C.) Branch to open a branch in Collingwood. *Henrietta (Kerr) Inglis* has resigned from the Sydney Branch.

Alberta Department of Public Health

Jean Blackbourne, after taking the advanced course in practical obstetrics at the University of Alberta, has returned to Grassland. *M. Augusta Evans*, after relieving in Grassland, is going south to Hilda.

Olive F. Watherston is back with Lindale district after a six-year leave of absence. She has been serving with the British Nursing Service in England during this war. She also served in the last war, and since that time has given many service-filled years to the Nursing Branch.

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Mrs. Dorothy (Colgan) Brickett is carrying on temporarily in Maloy. *Kay Macdonald* has left Lindale for Fort Assiniboine. *Mrs. Cathie Somerville* has exchanged Fort Assiniboine for Kinuso and replaces *Mrs. Dorothy Kaufman* who has resigned. *Aletha Knudson,* a new member of the staff, has replaced *Mrs. Vern Perkins,* who has resigned, in the Wainwright health district. A welcome is extended to *Camilla Gibson* who is from Yarmouth, N.S. *Margaret Burton* has taken the Rocky Mountain health district in hand. *Mrs. Pat (Routledge) Morgan* is carrying on temporarily in Strathmore. *Marguerite Weder* has taken over the McLennan-Spirit River health district, replacing *Kay Herman* who is now doing instructional work for the A.A.R.N. *Mrs. Cyril (Hedlin) Bailey* is carrying on part-time at Hemaruka. *P. A. Chapman* will presently be changing districts as Warburg is being closed due to Dr. Hankin's return to Thorsby from overseas.

Other resignations are as follows: *Mrs. Elizabeth (Wallwork) King-Hunter,* from Craigmyle to live in Sunnynook; *Frances Devlin,* from Hilda to be married; *Dorothy Haslam,* to take up missionary work.

British Columbia Public Health Nursing Service

The following are recent changes which have taken place in the public health nursing field staff:

Helen Etherington (Mack Training School, St. Catharines, Ont. and University of Toronto public health course) has been appointed to the staff of the Prince Rupert Health Unit.

Fern Primeau (Edmonton General Hos-

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pital and University of Alberta public health course) has been appointed nurse at Williams Lake.

Merle Frank (Victoria Hospital, London, Ont. and University of Western Ontario public health course) has been appointed nurse at Esquimalt.

Nancy McKinlay (Vancouver General Hospital and University of British Columbia public health course) has been appointed nurse at Princeton.

Eden Wayles and *Iris Williscroft* (St. Paul's Hospital, Vancouver, and University of B.C. public health course) have been appointed to the staff of the Cowichan Health Centre, Duncan.

Jessie Horne (University of Alberta Hospital and University of Alberta degree course) and *Mrs. Kirstine (Adam) Buckland* (Vancouver General Hospital and University of B.C. degree course) have been appointed to the staff of the Saanich Health Unit.

Nan Kennedy (Vancouver General Hospital and University of B.C. public health course) has been appointed nurse at Rossland.

Dorothy Udall (Vancouver General Hospital and University of B.C. public health course) has been appointed nurse at Prince George.

Frances Stewart (St. Paul's Hospital, Vancouver, and University of B.C. public health course) has been appointed nurse at Langley.

Violet Hele (St. Joseph's Hospital, Victoria, and University of B.C. public health course) has been appointed nurse at Campbell River.

Muriel McConnell (Saint John General Hospital, N.B. and University of Toronto public health course) has been appointed nurse at Langford.

Susie Jones (Toronto General Hospital and University of B.C. public health course) has been appointed to the staff of the Peace River Health Unit.

Mrs. Ruth (Wilkinson) McCubbin has resigned from the position of senior nurse on the staff of the Saanich Health Unit. *Margaret Williams* has resigned from the Similkameen public health service after two years' service at Keremeos. *Mrs. Jean (Dods) McAllister* has resigned from the Rossland

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Miss F. Munroe, R. N., Superintendent of Nurses, Royal Victoria Hospital, Montreal, P. Q.

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Superintendent of Nurses, Toronto Hospital, Weston, Ontario.

public health nursing district. *Mrs. Ann (Elyea) Hales* has resigned from the Surrey public health nursing district. *Mrs. Margaret (Robertson) Albrecht* has resigned from the Coquitlam and Fraser Mills public health nursing district.

Ontario

Public Health Nursing Service

Florence Greenaway (Toronto Western Hospital, and University of Toronto public health course) and *Bee McKerracher* (Ottawa Civic Hospital and University of Toronto public health course) have accepted positions with the Oshawa Board of Health.

Mary Scott (Hospital for Sick Children, Toronto, and University of Western Ontario public health course) and *Anne Earshman* (Belleville General Hospital and McGill School for Graduate Nurses public health course), both of whom have recently been released from service with the R.C.A.M.C., have accepted appointments with the Northumberland and Durham Health Unit.

Ida Gardiner (Diploma course, University of Toronto School of Nursing) has accepted an appointment with the East York Board of Health.

Jeannette Gillespie (Hospital for Sick Children, Toronto, and University of Toronto public health course), recently returned from service with the R.C.N.V.R., has accepted an appointment with the Windsor Board of Health.

Helen Gardner (St. Luke's Hospital, New York City, and University of Toronto public health course) has accepted a position with the Board of Health, Newmarket.

NEWS NOTES

NEW BRUNSWICK

ST. STEPHEN:

At a recent meeting of the St. Stephen Chapter, N.B.A.R.N., in response to a letter

read from the International Council of Nurses in which an appeal was made for food parcels for nurses of the Netherlands, it was decided to "adopt" a Dutch nurse and send her a box each alternate month. Contents and postage of boxes are to be paid from Chapter funds. After the business meeting, an interesting address and demonstration on "The Art of Weaving" was given by Miss Orr, dietitian at the Chipman Memorial Hospital. A social hour followed.

Theda Ingalls, a 1945 graduate of Chipman Memorial Hospital, is now matron of the Red Cross Outpost Hospital, North Head, Grand Manan. She was formerly a member of the staff at North Head.

ONTARIO

Editor's Note: District officers of the Registered Nurses Association may obtain information regarding the publication of news items by writing to the Provincial Convener of Publications, Miss Gena Bamforth, 54 The Oaks, Bain Ave., Toronto 6.

District 1

Chatham:

Recently a well-attended supper meeting of District 1, R.N.A.O., was held in Chatham, with May Jones presiding. The reports of the various committees were read and it was revealed that the response for aid to the nurses in Holland was very gratifying.

An interesting and instructive panel discussion took place, with topics and leaders as follows: What can hospitals do to control luxury nursing? Priscilla Campbell, Chatham. How much control has the hospital over graduate nurses in regard to personal appearance, use of supplies, and wearing of the uniform outside hospital grounds? Rahno Beamish, Sarnia. What are you doing to control use of drugs in your hospital? Sister Georgina, Chatham. What can the graduate nurse do to help the nursing situation in T.B. sanatoria and mental hospitals? Mabel Sharpe, Windsor. Newer emphasis in public health nursing, Mildred Walker, London.

Sarnia:

The Graduate Nurses Association of Sarnia has donated $35 to the New Nurses' Home Fund, and the Sarnia General Hospital Alumnae Association contributed a $500 Bond.

Audrey Acton is once again in charge of the S.G.H. operating room, following completion of a post-graduate course in surgery, operating-room technique and management at the New York City Hospital. Pearl Bloomfield has been discharged from the army and is now head nurse on the north surgical floor, S.G.H. Carol Sayers has completed a course in surgery at St. Luke's

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Registered nurses without preparation will be considered for temporary employment.

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114 Wellington Street,
Ottawa.

Hospital, Chicago, and is now on the operating room staff, S.G.H. Joyce Runsick has accepted a position at the King Edward VII Memorial Hospital, Bermuda. Letitia Lanin is at St. Luke's Hospital, Chicago, taking a course in surgery.

District 5

Toronto:

At a recent monthly meeting of the Toronto Western Hospital Alumnae Association Dr. William Keith, recently returned from Europe, was the guest speaker. His interesting talk on "Neurosurgery in Wartime" described the Canadian mobile neurosurgical units that were set up in England, Normandy, Belgium, and Holland. He mentioned that operative mortality in neurosurgery was reduced to 7 per cent throughout the war as compared with 35 per cent during World War I.

The following nursing sisters have recently returned from overseas where they served with the R.C.A.M.C.: Doris Kent, R.R.C.; Grace Patterson, R.R.C.; Elizabeth (McCulloch) Jones, returning to England to make her home there; Pauline Aitken, who served with the orthopedic unit in Scotland; N/Ss Jones, Sweden, Torrey, Coutts, McCormick, Houghtaling, Enid Falconer, Frances Matthews, Mary Craig, Vivian Bartlett, Doris Boddy, Margaret Dean, Margaret Carruthers, Bernice Seeds, Edna Benns, Ruth MacLean, Jean McCormack, Mary Bell, Helen Lane, Gertrude Hillock, Mabel Steen, Jean Taylor, Catherine Christie, Adaline Morrison, Jean Burt, Verda Smith, Fanny Arnott, Muriel Sutton, Irene (Bartlett) Stewart.

Myrtle Graham is now superintendent of nurses at the T.W.H.

District 6

Peterborough:

At a recent regular meeting of Chapter C, District 6, R.N.A.O., with twenty-eight members present, Mary Ross, the president, was in the chair. A letter from Matilda Fitzgerald regarding membership fee, and a circular concerning the disposal of unused narcotics were read. Mrs. Brackenridge gave the report on the General Nursing Section and N. Craig presented the Public Health Nursing Section report. L. Stewart introduced Dr. Kelly, medical officer of health for Peterborough, who spoke on "Health Insurance—A Form of Social Security". Sister Benedicta, St. Joseph's Hospital, Peterborough, conducted a discussion regarding simple procedures used in hospitals, with a demonstration in thermometer technique by Sister Benedicta and M. Pickens, Peterborough Civic Hospital. Others taking part in the discussion were M. Ross, V.O.N.,

J. Clarke, Department of Health, Peterborough, V. Bell, Isolation Hospital, and L. Stewart, Peterborough Clinic. Shirley Beer was in charge of the refreshments.

QUEBEC

MONTREAL:

Montreal General Hospital:

After a lapse of several years, the Governors' Ball again took place in the nurses' residence during Christmas week, with four hundred guests present. The excellent orchestra was much enjoyed and a delicious supper was served.

A recent sale, organized by the student nurses in aid of the "Save the Children Fund", realized over $200 and was well patronized. The sports program continues on its way under the leadership of K. Clifford and is much appreciated by all the staff, including the dietitians and some of the laboratory technicians. The basketball team is now included as a member of the Montreal Ladies' Basketball League, and a small gymnasium in a neighbouring school has been rented again this season for practices. The gymnasium at the Montreal High School is also used weekly. Edythe Ward, recently returned from South Africa, is back again as admitting officer at the Children's Memorial Hospital.

McGill School for Graduate Nurses:

The following nurses are taking postgraduate courses: Marjorie E. Cowan, certificate course in school of nursing administration; Jessie A. McCann, certificate course in public health nursing; Rita M. Myers, four-month course in administration and supervision in public health nursing. Mrs. J. E. Porteous has returned to complete her degree in administration in schools of nursing and Frances L. Winchester to complete the degree course in public health nursing. Marion Thompson, Helen Bright, and Julie Walters have returned to complete the degree course in teaching and supervision.

Recent visitors to the school were: Mrs. Mary V. MacPherson, Barbara M. Lever, Lillian Baird, Olive Bell, and Hazel MacDonald.

Mrs. E. V. LeBlond has returned as school nurse with the City of Westmount. Margaret Brady, formerly with the Child Welfare Association, is now supervisor with the Health Department, City of Westmount. Esther Robertson has recently been appointed national supervisor of the Western branches of the V.O.N. K. Oulton has been appointed school nurse with the City of Outremont. J. Hill is now with the Child Welfare Association, Montreal. Margaret Cogswell is the new director of the Nurse Placement Bureau of the Alberta Association of Registered Nurses.

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In the sick room

It coagulates and clears away offensive matter

SASKATCHEWAN

Moose Jaw:

The nurses' residence of the Moose Jaw General Hospital was the scene of a Christmas party recently when members of the local chapter of District 6, S.R.N.A., gathered for their monthly meeting. This meeting was held principally to introduce the senior student nurses of both hospitals to the chapter.

The business meeting was conducted by the president, Mrs. J. Droppo, who later introduced the speaker of th evening, Grace Giles, travelling instructor for the S.R.N.A. Her topic was "Social Relationships and Recreation" and her talk was both entertaining and instructive. Miss Rutherford extended the vote of thanks to Miss Giles. A draw was later made by Miss Giles for a tailored suit, the winner being Mrs. A. Smith. Part of the proceeds of the draw are to be used in purchasing and mailing parcels of food to nurses in the Netherlands, three of whom have been "adopted" by the S.R.N.A. P. McKenzie volunteeded to take charge of the purchasing and mailing of these parcels. In charge of arrangements for the social evening was Naomi Webber, assisted in serving by Misses Hagen, Haggerty, and Ruth Reid. Presiding at the urns were Mmes Banks and Cunningham. Incidental music was supplied by Beth Orrell.

Audrey Mulholland has accepted a position on the staff of the M.J.G.H., replacing Mrs. Wilkes who is leaving for California.

Regina:

Dorothy Bradley, who is to be married, is resigning as assistant superintendent of nurses, Regina General Hospital, and will live in Edmonton. Marjorie Nell succeeds her and F. Copeman will take over Miss Nell's present duties.

L. Cranston has been appointed to the graduate staff in the operating-room of the Grey Nuns' Hospital. I. Thompson is in charge of the third floor nursing station. Rev. Sr. Miller has assumed the position of assistant superintendant of nurses at the Grey Nuns' Hospital.

Yorkton:

Following a recent business meeting of the Yorkton Chapter, District 4, S.R.N.A., a social evening was enjoyed at which Miss Rogerson, social welfare worker in the district, gave an interesting talk on the services of the Social Welfare Organization. A gift was presented to Mrs. Betty Hannan who is leaving shortly to join her husband in Australia. Ellen Anderson is taking a post-graduate course in pediatrics at the Winnipeg Children's Hospital. A successful bazaar and tea, featuring children's clothing and toys, was recently held in the nurses' residence.

Brightening Up

Some of the colour combinations being instituted in the schools of New York State might be usefully employed in the redecoration of rooms, corridors,etc., in our hospitals. The new colour schemes are designed to blend the most soothing shades of the spectrum and provide what is described as "a for more homelike atmosphere". The colours chosen are combinations of blue, rose, silver-gray, pale green, blue green, gray-green, and yellow. Two soft colours are used for the walls with white or cream for the ceiling. These were shown in the survey to have the best esthetic effect together with the practical consideration of light reflection and maintenance.

The new painting program is conducive of better work and a new personal pride in the school room on the part of each child, because the variety of colour schemes will do much to dispel the institution atmosphere and replace it with a home atmosphere — a place where children and teachers will enjoy working together.

The approved combinations call for an array of shades in contrast to the cream walls and buff dados now in use. One combination, for instance, uses a dark silver dado with pale silver walls. A gayer design is that of the yellow room with light blue dado, while a warm cream room with a copper rose dado is almost equally as gay in its appearance. The fifth combination is a light green room with a gray-green dado.

In each case, the dado is the area rising about four feet above the floor which takes the brunt of the wear and is, therefore, painted a darker shade. The upper walls are done in lighter shades to increase the light reflection as well as to provide the pleasing contrast with the lower walls.

The Eiffel Tower in Paris is considered ruined due to the fact that its filmy web of intricate steel was allowed to go unpainted during the entire German occupation of Paris, with the result that rust and decay has become far advanced.

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Written specially for the student nurse, this is also a very valuable book for the graduate. The author has for many years lectured to student nurses. She has shown her knowledge of psychology in writing the book, closely relating its subject matter to the day-to-day life of the nurse. The book follows closely the general plan outlined in the "Curriculum Guide for Schools of Nursing," and covers all phases of the work. 336 pages. $4.25.

THE RYERSON PRESS

TORONTO

WANTED

A **Matron** is required for a 30-bed hospital, 120 miles from Montreal. Excellent living conditions. Supervisory work only. Knowledge of French preferred. For further particulars apply to:

Dr. H. S. Hooper, Laurentide Hospital, Grand'Mere, P. Q.

WANTED

Applications are invited for the position of **Instructress** at the **Royal Victoria Hospital, Barrie, Ontario.** Maintenance is furnished. Applicants should apply at once, stating qualifications and salary expected to:

Miss E. A. Williams, Supt., Royal Victoria Hospital, Barrie, Ont.

WANTED

Applications are invited for the following positions in the **Prince County Hospital:**

Superintendent
Assistant Night Superintendent

Apply at once by mail, stating experience, and salary required, to:
Secretary, Prince County Hospital, Summerside, P.E.I.

WANTED

Verdun Protestant Hospital desires applications from nurses for **General Staff Duty.** State in first letter, date of graduation, experience, and when services would be available. Registered Nurses are also required for the position of **Assistant Night Supervisor** and as **Charge Nurses** for wards. Apply to:

Director of Nursing, Verdun Protestant Hospital, Box 6034, Verdun, P. Q.

WANTED

A Graduate nurse, with Operating Room experience, is required for the **Barrie Memorial Hospital.** Apply to:

Superintendent, Barrie Memorial Hospital, Ormstown, P. Q.

WANTED

A class room **Instructress** for a 120-bed hospital. Apply stating qualifications, experience and salary expected, to:

The Superintendent, Stratford General Hospital, Stratford, Ont.

WANTED

Registered Nurses are required for **General Duty** in a 90-bed hospital on Okanagan Lake. 8-hour day and 6-day week. Salary, $85 to $90 per month living in. One month vacation each year. Apply to:

Miss E. I. Stocker, Supt., Kelowna General Hospital, Kelowna, B.C.

WANTED

Vancouver General Hospital desires applications from Registered Nurses for **General Duty.** State in first letter date of graduation, experience, references, etc., and when services would be available.

Eight-hour day and six-day week. **Salary:** $95 per month living out, plus $19.92 Cost of Living Bonus, plus laundry. One and one-half days sick leave per month accumulative with pay. Employees' Hospitalization Society. Superannuation. One month vacation each year with pay. Investigation should be made with regard to registration in British Columbia. Apply to:

Miss E. M. Palliser, Director of Nurses, Vancouver General Hospital
Vancouver, B. C.

WANTED

A **Graduate Nurse,** with secretarial training and executive experience, is required to assist in a Nursing Office. Headquarters in Toronto. Submit references. Apply in care of:

Box 2, The Canadian Nurse, 522 Medical Arts Bldg., Montreal 25, P. Q.

WANTED

An **Operating Room Supervisor** and **Night Supervisor** are required for a 50-bed hospital. Apply, giving full particulars, to:

Superintendent, Cottage Hospital, Pembroke, Ont.

WANTED

A **Superintendent of Nurses** is required for a 120-bed Public Hospital with Training School. Duties are to commence on **May 1.** Apply, with photograph, giving full particulars in first letter of qualifications, experience, necessary personal information (age, etc.), and salary expected to:

Secretary-Treasurer, Board of Management, Galt Hospital, Lethbridge, Alta.

WANTED

A **Science Instructor** is required by **August 1, 1946,** for the **Peterborough Civic Hospital (formerly the Nicholls Hospital).** Apply to:

Superintendent of Nurses, Peterborough Civic Hospital, Peterborough, Ont.

WANTED

The **Salvation Army Grace Hospital, Ottawa,** (women's hospital specializing in Obstetrics), desires applications from Registered Nurses for the positions of **Night Supervisor** and **Assistant.** Positions available **immediately.** Salary, $140 and $120 respectively. Living out. Letters should state date of graduation, experience, references, etc. Apply to:

Superintendent of Nurses, Grace Hospital, Ottawa, Ont.

WANTED

An **Operating Room** nurse is required for a 200-bed hospital. 8-hour day and 6-day week. The salary is $85 per month, with full maintenance. One month's vacation each year with pay. Apply to:

Miss Dora Parry, Supt. of Nurses, Children's Memorial Hospital,
Montreal 25, P. Q.